

KF
3826
.C48
A2
2007

THE CHILDREN'S HEALTH AND MEDICARE PROTECTION ACT OF 2007 SECTION-BY-SECTION ANALYSIS

TITLE I. CHILDREN'S HEALTH

Subtitle A -- Funding

Sec. 100. Purpose. Establishes the purpose of Title I to stabilize funding under title XXI and XIX in order to enroll all six million children who are eligible but not enrolled for coverage today.

Sec. 101. Establishment of new base CHIP allotments. Establishes a new State-specific federal allotments for CHIP. Allotments would be the greater of a State's projections for FY08 as reported in May of 2007 or the State's FY 07 allotment increased by child population growth and per capita national health care expenditure growth. For States that experience a shortfall and who have enrolled children who are eligible but not currently enrolled in CHIP, this section also provides a payment equal to the State's average per capita federal expenditure for a child.

Sec. 102. 2-year initial availability of SCHIP allotments. Provides states two years to spend the federal CHIP allotment for any given year.

Sec. 103. Redistribution of unused allotments to address State funding shortfalls. Establishes a system for redistributing any State allotments unspent after two years. The method for redistribution (evenly distributed to the shortfall states) is the same as used for previous shortfall adjustments enacted by Congress.

Sec. 104. Extension of option for qualifying States. Permanently extends the option for "qualifying states" to use a portion of their CHIP allotment for children covered through Medicaid and increases the amount of the allotment that can be spent on such coverage.

Subtitle B—Improving Enrollment of Eligible Children

Sec. 111. SCHIP performance bonus payment to offset additional enrollment costs resulting from outreach, enrollment, and retention efforts. Provides a performance bonus payment for States that enroll children above their baseline and adopt five of seven outreach and enrollment best practices: 12-month continuous eligibility; administrative verification of assets; elimination of the in-person interview requirement; use of a joint application for Medicaid and CHIP; automatic renewal; presumptive eligibility; express lane eligibility. The performance bonus is available for enrollment of children who are currently eligible for CHIP or Medicaid today but are not today enrolled.

LAW
KF
3826
C48
A2
2007

Sec. 112. State option to rely on findings from an express lane agency to conduct simplified eligibility determinations. Provides States a new tool for outreach, called Express Lane Eligibility (ELE). States that elect the ELE option could use a finding from an ELE agency to expedite eligibility determinations by CHIP or Medicaid.

Sec. 113. Application of Medicaid outreach procedures to all children and pregnant women. Allows States to apply outreach procedures to all children and pregnant women.

Sec. 114. Encouraging culturally appropriate enrollment and retention practices. Provides additional federal funding for culturally appropriate enrollment and retention activities.

Subtitle C—Coverage

Sec. 121. Ensuring child-centered coverage. Improves CHIP coverage by adding a guaranteed dental benefit for children. It would require parity for mental health coverage under benchmark plans and guarantee access to federally qualified health centers (FQHCs) and rural health centers (RHCs). The FQHC's and RHC's would also be paid under a prospective payment system. The provision also clarifies that school clinic services may be covered under CHIP.

Sec. 122. Improving benchmark coverage options. Ensures that Secretary-approved benchmark coverage is no less protective for children than the coverage offered in other benchmark options. This section also clarifies that the state employee coverage benchmark option is the option most frequently selected by employees seeking family coverage.

Sec. 123. Premium grace period. Grants families a 30-day grace period for premium payment under CHIP before termination of a child's coverage.

Subtitle D—Populations

Sec. 131. Optional coverage of older children under Medicaid and SCHIP. Grants States the option to cover children who otherwise age out of CHIP or Medicaid. States that elected this option could cover children above existing eligibility levels, through age 24.

Sec. 132. Optional coverage of legal immigrants under the Medicaid program and SCHIP. Provides States the option to cover legal immigrant children and legal immigrant pregnant women in CHIP or Medicaid. A State may only cover these individuals in CHIP if the State also elects to cover such individuals in Medicaid.

Sec. 133. State option to expand or add coverage of certain pregnant women under CHIP. Provides a new eligibility option in CHIP for States to cover pregnant women. A State may exercise this option if the State covers pregnant women under Medicaid to 185% of the federal poverty level, covers children in families with incomes up to 200%

of the federal poverty level, and does not impose a waiting list for enrollment of children under CHIP. States that previously covered pregnant women at higher income levels through Medicaid may use up to 30 percent of their CHIP allotment for such coverage. This section also automatically enrolls children born to mothers covered under CHIP or Medicaid in coverage upon birth and allows entities that conduct presumptive eligibility for children to do so for pregnant women.

Subtitle E—Access

Sec. 141. Children’s Access Payment and Equity (CAPE) Commission. Creates a new federal Commission, modeled after the Medicare Payment Advisory Commission (MedPAC), to monitor access and quality of care for children under CHIP and Medicaid as well as adequacy of provider payments, including safety net providers.

Sec. 142. Model of Interstate coordinated enrollment and coverage process. Directs the Government Accountability Office (GAO) to work with stakeholders to develop model practices to facilitate enrollment of children who live in families that move frequently around the United States.

Sec. 143. Medicaid citizenship documentation requirements. Amends the requirements for documenting citizenship and identity to allow individuals a reasonable period of time to gather necessary information, allow newborns to meet requirements more easily, and allow additional tribal membership documents to be used as satisfactory evidence of citizenship or nationality. This section also allows states the option of returning to pre-July 1, 2006 documentation requirements for children, so long as the State submits to an audit of a sample of cases to demonstrate compliance.

Sec. 144. GAO study of access to dental services for children. Provides for a study by the Government Accountability Office on access to dental services in underserved areas.

Sec. 145. Prohibiting initiation of new health opportunity account demonstration programs. Prohibits additional health opportunity account demonstrations.

Subtitle F—Quality and Program Integrity

Sec. 151. Pediatric health quality measurement program. Establishes a pediatric health care quality measurement program to develop and implement measures of pediatric clinical quality and measures of overall program quality. These measures will specifically examine disparities in care based on age, race, ethnicity, and geography.

Sec. 152. Application of certain managed care quality safeguards to CHIP. Applies managed care quality protections such as the quality assurance standards, protections against fraud and abuse, and the “prudent layperson” standard for access to emergency care to managed care organizations in CHIP.

Sec. 153. Updated Federal Evaluation of CHIP. Provides for a new federal evaluation of the CHIP program in 2010, modeled after the initial evaluation completed in 2005.

Sec. 154. References to title XXI. Repeals section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

Sec. 155. Reliance on law; exception for State legislation. Allows for good-faith implementation of provisions by States prior to CMS regulatory action and allows flexibility in effective dates for States which need legislation to comply with the provisions of this title or title VIII.

TITLE II: MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A – Improvements in Benefits

Sec. 201. Coverage and waiver of cost-sharing for preventive services. Effective January 1, 2008, allows the Secretary of Health and Human Services to add new benefits for preventive items and services, including mental health services, that are reasonable and necessary for the prevention or early detection of an illness or disability. Requires the Secretary to take into account evidence-based recommendations of the United States Preventive Services Task Force and other appropriate organizations when creating new benefits. Eliminates co-insurance for and exempts from deductible current preventive benefits and future preventive benefits added through this process. Requires new preventive benefits to be included as part of the initial “Welcome to Medicare” physical.

Sec. 202. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal. Effective January 1, 2008, clarifies that the deductible is waived for a screening colonoscopy even if a diagnosis is established as a result of a test or tissue is removed during the procedure.

Sec. 203. Parity for mental health coinsurance. Reduces coinsurance for outpatient mental health services by five percentage points annually from 50 percent to 20 percent by 2012.

Subtitle B—Improving, Clarifying, and Simplifying Financial Assistance for Low-Income Medicare Beneficiaries

Sec. 211. Improving assets tests for Medicare Savings Program and Low-Income Subsidy program. Increases the amount of allowable resources to \$17,000 for an individual and \$34,000 for a couple in order to qualify for assistance with Medicare Part B and D costs. Starting in 2010, the limit is increased annually by \$1,000 per individual and \$2,000 per couple.

Sec. 212. Making QI program permanent and expanding eligibility. Makes permanent the Qualified Individual (QI) program that provides assistance with premiums for certain low-income beneficiaries, which otherwise expires on September 30, 2007. Raises the QI income level to 150% of the federal poverty level, or \$15,315 for an individual in 2007.

Sec. 213. Eliminating barriers to enrollment. Provides for administrative verification of income and resources for individuals under the Low-Income Subsidy (LIS) program as well as automatic renewal without the need to reapply. Directs the Secretary of Health and Human Services to take all reasonable steps to encourage States to adopt these enrollment simplifications in the Medicare Savings Programs (MSP).

Directs the Commissioner of Social Security to provide applications for MSP and LIS to individuals applying for Medicare benefits and to provide assistance in completing such applications at the request of the beneficiary. Requires the Commissioner to forward completed MSP applications to States for eligibility determinations. Requires the Secretary of Health and Human Services to translate the existing simplified MSP form into at least the ten languages most often used by individuals applying for benefits under title II or title XVIII. Allows the Commissioner of Social Security to obtain data from IRS to identify beneficiaries potentially eligible for the LIS.

Sec. 214. Eliminating application of estate recovery. Eliminates the requirement that States recover costs from the estate of individuals receiving assistance with Part B costs beginning in 2008.

Sec. 215. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals. Ensures that dual eligible beneficiaries receiving care through a home- and community-based care waiver are treated the same with respect to cost sharing under Part D as beneficiaries who are in nursing homes. This ensures the lowest income Medicare beneficiaries can choose to receive care in the least restrictive community setting without penalty.

Sec. 216. Exemptions from income and resources for determination of eligibility for low-income subsidy. Exempts the balance of a pension and retirement plan and the value of a life insurance policy from LIS resource determinations. It also exempts in-kind support and maintenance (e.g., assistance provided by a family member or church) from LIS income determinations. The protections begin in 2009.

Sec. 217. Cost-sharing protections for low-income subsidy-eligible individuals. Caps out-of-pocket spending under Part D to 2.5 percent of income annually for the lowest income Medicare beneficiaries (\$15, 315). These protections begin in 2009.

Sec. 218. Intelligent assignment in enrollment. Ensures the lowest income Medicare beneficiaries who are automatically assigned to a Part D plan, are assigned to a plan that: (1) covers 95 percent of the 100 brand drugs most commonly used by Medicare beneficiaries; (2) covers 95 percent of the 100 generic drugs most commonly used by Medicare beneficiaries; (3) provides pharmacy access that exceeds minimum standards, including access in areas where low income beneficiaries reside; and (4) has a total cost among the lowest 25th percentile of plans where the beneficiary resides. This provision takes effect in 2009.

Subtitle C—Part D Beneficiary Improvements

Sec. 221. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out of pocket threshold under Part D. Allows costs for Part D prescription medicines paid by the Indian Health Service (IHS) or an AIDS Drug Assistance Program (ADAP) to count toward a beneficiary's total out-of-pocket Part D spending beginning in 2009 for purposes of filling the donut hole.

Sec. 222. Permitting mid-year changes in enrollment for formulary changes adversely impact an enrollee. Allows a beneficiary to change to a new plan if their plan has a mid-year material change in the formulary that reduces access to their prescribed drug (unless such change was required for safety reasons). This provision takes effect in 2009.

Sec. 223. Removal of exclusion of benzodiazepines from required coverage under the Medicare prescription drug program. Allows Part D plans to cover benzodiazepines, which are commonly used by individuals with mental illness. This provision takes effect in 2009.

Sec. 224. Permitting updating drug compendia under part D using part B update process. Allows the Secretary to update compendia used under Part D using a process similar to the one in place under Part B.

Sec. 225. Codification of special protections for six protected drug classifications. Codifies the Secretary's guidance relating to coverage of the "six protected classes" of drugs under Part D, anti-convulsants, anti-neoplastics, anti-retrovirals, anti-depressants, anti-psychotics, and immunosuppressants. It also clarifies that plans may only use prior-authorization or step therapy when approved by the Secretary.

Sec. 226. Elimination of Medicare part D late enrollment penalties paid by low-income subsidy-eligible individuals for periods. Eliminates the Part D late enrollment penalty for low-income subsidy eligible individuals to ensure Part D coverage is available without penalty.

Sec. 227. Special enrollment period for subsidy eligible individuals. Provides for a special enrollment period for LIS subsidy-eligible individuals, allowing up to 90 days after notification of LIS status, to select a Part D plan or Medicare Advantage plan that covers prescription drugs. This provision takes effect in 2008.

Subtitle D—Reducing Health Disparities

Sec. 231. Medicare data on race, ethnicity, and primary language. Requires the Secretary to collect, analyze, and report data on race, ethnicity, and primary language of Medicare beneficiaries.

Sec. 232. Ensuring effective communication in Medicare. Requires the Secretary to conduct a study on Medicare payments for language services, and provides for additional enforcement.

Sec. 233. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing Medicare reimbursement for culturally and linguistically appropriate services. Requires CMS to conduct a demonstration of the effect of Medicare reimbursement for culturally and linguistically appropriate services.

Sec. 234. Demonstration to improve care to previously uninsured. Requires CMS to conduct a demonstration to improve outreach to and support for Medicare beneficiaries who were previously uninsured.

Sec. 235. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare. Requires the Office of the Inspector General to study and report on the extent to which Medicare providers are complying with CLAS standards, and the extent to which non-compliance is being enforced.

Sec. 236. IOM Report on impact of language access services. Requires the Institute of Medicine to conduct a study and issue a report on the effect of language access services on access to and quality of care.

Sec. 237. Definitions. Defines terms used in this section.

TITLE III -- MEDICARE PHYSICIAN PAYMENT REFORM

Sec. 301. Establishment of separate target growth rates for service categories. Provides for a 0.5 percent update in 2008 and 2009. Replaces the Sustainable Growth Rate (SGR) methodology with a system of separate updates for six categories of physician services within the Medicare fee schedule: Primary and Preventive Services, Other Evaluation and Management Services, Major Procedures, Anesthesia Services, Imaging Services, Minor Procedures and Other Services. Primary Care and Preventive Services Category annual allowed growth would equal growth in the gross domestic product (GDP) plus 3 percent; annual allowed growth for other service categories would equal the GDP growth. Future fee schedule updates would take into consideration the prior "overhang" of accumulated excess expenditures under the SGR system, but would not incorporate growth of expenditures for clinical diagnostic laboratory tests or drugs and would include national coverage determinations as allowed growth. Requires the Secretary to annually report growth of expenditures for clinical diagnostic laboratory tests or drugs in the physician fee schedule proposed rule, including analysis of reasons for such growth and recommendations for addressing it.

Sec. 302. Improving accuracy of relative values under the Medicare Physician Fee Schedule. Establishes an expert panel to identify physicians' services for which the relative value is potentially misvalued. The Secretary would also identify physician services growing at an unusually high annual rate and would have the authority to reduce the work value of specific physician services after consultation with the expert panel and consideration of evidence supporting the clinical appropriateness of the observed rapid growth.

Sec. 303. Physician Feedback mechanism on practice patterns. Requires the Secretary to implement a system of confidential feedback to physicians in the Medicare program on how their practice patterns compare to other physicians both in the same locality as well as nationally.

Sec. 304. Payments for efficient physicians. Provides a 5 percent bonus for Medicare physicians practicing in counties in the lowest 5th percentile of per capita spending.

Sec. 305. Recommendations on refining the Physician Fee Schedule. Requires GAO to conduct an analysis of codes paid under the Medicare physician fee schedule to determine whether the codes for procedures that are commonly furnished together should be combined and/or payments adjusted; GAO would also analyze the Medicare physician fee schedule to identify opportunities for increased use of "bundled" payment methodologies.

Sec. 306. Improved and expanded Medical Home Demonstration Project. Initiates a nationwide project involving up to 500 medical practices, especially those serving communities whose populations are at higher risk for health disparities. The Secretary would certify practices to be eligible for payment for "Medical Home" services, actively managing and coordinating care for participating beneficiaries. The Secretary would also certify practices using robust health information technology (HIT) in their medical home model, and would conduct a separate study of the additional costs and benefits of the "HIT enhanced medical home."

Sec. 307. Repeal of Physician Assistance and Quality Initiative Fund. Repeals the bonus fund for the Physician Assistance and Quality Initiative, but allows the program to continue on a voluntary basis.

Sec. 308. Adjustment to Medicare payment localities. Requires CMS to revise payment localities in California by January 1, 2008, and in multi-locality states by January 1, 2011. Provides for transition funding for counties in California that would otherwise experience losses as a result of the revised localities.

Sec. 309. Payment for Imaging Services. Establishes an accreditation process for facilities that provide diagnostic imaging services and requires that a facility be accredited in order to receive reimbursement for imaging services from Medicare. Requires CMS to increase their assumption on the amount of time imaging equipment is in use from 50 percent to 75 percent. Requires a 50 percent reduction in the technical component for imaging services involving contiguous body parts. Requires CMS to assume that the interest rate for capital purchases reflects the prevailing rate in the market, but in no case higher than 11 percent. Disallows global billing.

Sec. 310. Repeal of Physicians Advisory Council. Repeals the Practicing Physicians Advisory Council.

TITLE IV – MEDICARE ADVANTAGE REFORMS

Subtitle A – Payment Reform

Sec. 401. Equalizing payments between Medicare Advantage plans and fee-for-service Medicare. Phases-out overpayments to MA plans over four years to 100% FFS in 2011. The phase-out of payments in excess of 100% FFS would be a blend of the current county benchmarks adjusted for the applicable year and 100% of county FFS costs in the projected year. In 2009, the benchmarks would be a blend of 2/3 current benchmark and 1/3 100% FFS in the county; in 2010, the blend would be 1/3 current benchmark and 2/3 100% FFS. In 2011, and subsequent years, all MA benchmarks would be set at 100% FFS costs in the county.

Provides that MA plans that indicate in their bids that they cannot provide Medicare Part A and Part B services for less than 106% of FFS costs in 2009 and 103% in 2010 may not enroll new beneficiaries in those years.

Eliminates the remaining authority for spending from the regional PPO stabilization fund in 2012 and 2013.

Subtitle B – Beneficiary Protections

Sec. 411. NAIC development of marketing, advertising and related protections. Requests the National Association of Insurance Commissioners (NAIC) to develop model marketing, advertising and related beneficiary protections for MA and Part D plans. Requires the model regulations to include standards for marketing activities, ensure appropriate beneficiary education, set standards for training and certification, limit agent and broker commissions and conduct market conduct surveys. Increases penalties for violations of these protections.

The NAIC would consult with a working group of representatives of MA plan representatives, consumer groups, Medicare beneficiaries, and State Health Insurance Programs. Provides for the NAIC to promulgate model regulations 12 months from date of enactment.

Expands the role of state oversight of agents, brokers and MA plans. The model marketing regulations would be a condition of all plan contracts. Requires the Secretary to publicly disclose MA plan violations of the marketing and enrollment standards.

Increases funding to State Health Insurance Assistance Programs (SHIPs).

Sec. 412. Limitation on out-of-pocket costs for individual services. Limits out-of-pocket costs in MA plans for any service to no more than the amount of cost-sharing for

the same service in FFS Medicare. Limits out-of-pocket costs in MA plans for Medicaid beneficiaries to the amount of cost-sharing for the same service in Medicaid in the State.

Sec. 413. MA plan enrollment modifications. Revises MA plan enrollment practices to provide continuous open enrollment for full Medicaid dual eligibles and Qualified Medicare Beneficiaries (people with incomes up to 100% of poverty). Provides special election periods to additional beneficiaries with special health needs. Extends the period that Medicare beneficiaries may return to their previous Medigap plan to 24 months. Prohibits auto-enrollment of Medicaid beneficiaries into a MA plan.

Sec. 414. Information for beneficiaries on plan administrative costs and services. Provides for each MA plan Medicare Loss Ratio and other information, to be publicly reported in September of each year prior to the fall MA plan open enrollment period. The MLR information would use data currently submitted as part of the MA bid process. Standardized data elements and definitions for the calculation of the MRL would be developed for implementation in 2010. Plans that do not have a minimum MLR of .85 beginning in 2010 would face benchmark reductions, limits on new enrollment and, after year 5 years, exclusion from the MA program. Provides for additional MA program information to be routinely published.

Subtitle C – Quality and Other Provisions

Sec. 421. Requiring all MA plans to meet equal standards. Equalizes the playing field across types of MA plans by requiring PFFS and PPO plans to report the same data reported by Coordinated Care Plans for HEDIS, CAHPS and HOS quality measures beginning in 2010.

Requires employer plans to have 90% of their members in counties where the MA plan firm has a plan available to local residents. The MA provisions of the CHAMP Act could not be waived for employer plans.

Sec. 422. Developing new quality reporting measures on racial disparities. New HEDIS measures to assess disparities in the amount and quantity of health services provided to racial and ethnic minorities would be developed. HHS would return to its previous practice of issuing biennial reports on disparities in MA plan services to minorities.

Sec. 423. Strengthening audit authority. Audits would be required for risk adjustment data in a manner similar to audits of other MA plan data. Provides HHS the authority necessary to address deficiencies identified in MA plan audits.

Sec. 424. Improving risk adjustment for MA plans. The adequacy of the MA risk adjustment system with a focus on its accuracy in predicting the costs of enrollees with multiple chronic diseases would be analyzed by HHS and a report to Congress submitted within one year.

Sec. 425. Eliminating special treatment of private fee-for-service plans. Special features of the MA program for PFFS plans would be eliminated. Hospitals, physician

and other providers would not be permitted to extra-bill PFFS plan members by 15%; HHS would review PFFS plan bids in a fashion similar to other MA plans.

Sec. 426. Renaming of MA program. The Medicare Advantage program would be renamed the Medicare Part C program.

Subtitle D – Extension of Medicare Advantage Authorities

Sec. 431. Extension and revision of authority for Special Needs Plans. The authority for MA SNPs would be revised and extended for 3 years through 2011. SNPs would continue to be paid the same manner and amounts as other MA plans. The authority for dual Medicare-Medicaid SNPs would be revised to require that dual-SNP plans have: 90% enrollees that are full-dual eligible or QMB Medicaid beneficiaries; an agreement with a State Medicaid agency regarding cooperation on the coordination of the financing of care and, beginning in 2011, a contract with the State Medicaid agency for capitation payments for supplemental Medicaid benefits.

The authority for institutional SNPs would be revised to require that institutional-SNP plans have: 90% enrollees that are residents of long-term care facilities; contracts with long-term care facilities sufficient to meet the needs of its enrollees; and an agreement with a State Medicaid agency regarding cooperation on the coordination care.

All SNPs would report data for new HEDIS measures especially developed for quality of care for SNP beneficiaries. Plans that were part of State demonstrations in 2004 would not be required to meet the new requirements for SNP plans.

The authority for chronic disease SNPs is not extended and would expire in at the end of 2009. All MA plans would continue to be required to have a chronic care improvement program. Chronic disease plans may continue to operate as regular MA plans.

Sec. 432. Extension and revision of authority for Medicare reasonable cost contract plans. The authority for MA cost plans would be revised and extended for 3 years through 2011. Cost plans would continue to be paid under the current cost reimbursement system.

Provisions that currently apply to MA risk plans and would now apply to cost plans include: approved marketing materials and application forms; a quality program; grievance mechanisms; and coverage determinations.

TITLE V -- MEDICARE PART A

Sec. 501. Inpatient hospital payment updates. Provides for 0.25% market basket reduction for fiscal year 2008.

Sec. 502. Payments for inpatient rehabilitation facility (IRF) services. Provides a one percent increase in rates for fiscal year 2008. Permanently freezes implementation of the "75 percent" rule at 60 percent. Reduces rates for hip and knee replacements and hip fractures. Directs research on outcomes, costs, and other factors needed to evaluate the value of services provided.

Sec. 503. Payments and coverage for long term care hospitals.

- Creates specific patient and facility criteria to clearly define long-term care hospitals (LTCHs) and the patients who belong there and directs the Secretary to develop additional criteria as recommended by MedPAC;
- Expands the current medical necessity review of LTCH admissions and continued stays to ensure that clinically appropriate patients are admitted;
- Imposes a 4 year moratorium on the development of new LTCHs and expansion of existing LTCHs to address concerns about growth;
- Prevents the current "25% Rule" pertaining to hospital referrals from being extended to freestanding and grandfathered LTCHs;
- Freezes the "25% Rule" at its current level for co-located, rural or MSA dominant LTCHs;
- Protects patient access by limiting a regulation on short stay outliers;
- Prevents imposition of a one-time budget neutrality adjustment.
- Freezes payment rates for long term care hospitals for rate year 2008.

Sec. 504. Increasing the disproportionate share (DSH) adjustment cap for rural hospitals. Raises the DSH cap for rural and small urban facilities to 16 percent in 2008 and 18 percent in 2009.

Sec. 505. Long-stay cancer hospitals. Exempts long-stay cancer hospitals from the long term care hospital prospective payment system.

Sec. 506. Skilled nursing facility update. Freezes payments to skilled nursing facilities for fiscal year 2008.

Sec. 507. Revocation of deeming authority of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Repeals JCAHO's unique statutory protection, effective 18 months after date of enactment. Provides that validation surveys are conducted to review effectiveness of accrediting organizations that accredit at least XX percent of facilities in the field in question.

Sec. 508. Delay in effectiveness of certain provisions. Limits implementation of market basket changes in sections 501, 502, 503 and 506, so that changes are effective January 1, 2008.

SUBTITLE B – Extension of Medicare Rural Access Protections

Sec. 621. 2-year extension of floor on Medicare work geographic adjustment. Extends for two years the work geographic floor of 1.0 for any locality for which such index was below 1.0.

Sec. 622. 2-year extension of special treatment of certain physician pathology services under Medicare. Extend for two years the provision that allows independent laboratories providing services to hospitals that utilized independent laboratories prior to the CMS November 1999 final physician fee schedule rule to continue to bill Medicare directly for the physician pathology services they provide to hospitals.

Sec. 623. 2-year extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas. Provides reasonable cost reimbursement for clinical lab tests performed by rural hospitals as part of their outpatient services (i.e. for area patients receiving care at home or in nursing homes) through 2010.

Sec. 624. 2-year extension of Medicare incentive payment program for physician scarcity areas. Extend provision which automatically qualifies physicians practicing in counties ranked in the bottom 20th percentile nationwide for a 5 percent bonus payment through 2010.

Sec. 626. 2-year extension of temporary Medicare payment increase for ambulance services in rural areas. Increases payments by 2 percent for rural ground ambulance services through 2010.

Sec. 627 Extending hold harmless for small-hospitals under the HOPD prospective payment system. Extends for two years the provision for hospitals with less than 100 beds harmless that provides a 90 percent “hold harmless” from the Medicare outpatient prospective payment system (PPS).

SUBTITLE C – END STAGE RENAL DISEASE PROGRAM

Sec. 631. Support of public and patient education initiatives regarding kidney disease. Creates demonstration projects to test ways to increase public and medical awareness of factors that lead to chronic kidney disease, increasing screening and prevention, and enhance surveillance systems.

Sec. 632. Medicare coverage of kidney disease patient education services. Provides up to six patient education sessions for pre-dialysis (Chronic Kidney Disease State 4) Medicare beneficiaries.

Sec. 633. Requiring training for patient care dialysis technicians. Requires training and certification for patient care dialysis technicians.

Sec. 634. MedPAC report on treatment modalities for patients with kidney disease. Mandates a report by the Medicare Payment Advisory Commission on Medicare payment adequacy and recommendations for home dialysis.

Sec. 635. Adjustment for erythropoietin stimulating agents (ESAs). Adjusts payments for ESAs for large dialysis organizations.

Sec. 636. Site neutral composite rate. Creates a site-neutral composite rate for dialysis services.

Sec. 637. Development of ESRD bundling system and quality incentive payments. Starting in 2010, creates a bundled payment for dialysis and related drugs and services, with certain requirements to ensure appropriate anemia management. Allows for a four year phase-in for certain providers. Provides quality incentive payments for dialysis providers for 2008 through 2011.

Sec. 638. MedPAC report on ESRD bundling system. Mandates a report by the Medicare Payment Advisory Commission on payment adequacy under a bundled payment system.

Sec. 639. OIG Study and report on erythropoietin. Mandates a report by the HHS Office of the Inspector General on anemia management dosing guidelines and the extent to which such guidelines are consistent with the Food and Drug Administration's label for anemia management drugs.

Sec. 640. Chronic kidney disease demonstration projects.

TITLE VII -- MEDICARE PARTS A and B

Sec. 701. Home health payment update for 2008. Provides zero update for home health services for FY 2008.

Sec. 702. 2-year extension of temporary Medicare payment increase for home health services furnished in rural areas. Extends for two years a 5% add-on payment for rural home health services.

Sec. 703. Extension of Medicare secondary payer for beneficiaries with end stage renal disease for large group plans. Extends Medicare Secondary Payer to 42 months for beneficiaries with health insurance coverage from large employers (100+ employees).

Sec. 704. Plan for Medicare payment adjustments for never events. Requires HHS to develop a plan to identify steps needed to implement a system to prohibit Medicare payment for so-called "never events" or mistake procedures.

Sec. 705. Treatment of Medicare hospital reclassifications. Extends for two years the provisions of the Medicare Modernization Act of 2003 relating to wage index reclassifications.

Title VIII - MEDICAID

Subtitle A – Protecting and Extending Existing Coverage.

Sec. 801. Modernizing transitional Medicaid. Extends the Transitional Medical Assistance program (TMA) through Fiscal Year 2009, provides States the option to provide twelve months of continuous eligibility for families transitioning from welfare to work, [allows states the option to provide TMA to families who spent fewer than three months receiving TANF-related medical assistance], and enhances reporting on enrollment and participation under TMA.

Sec. 802. Family planning services. Allows states to offer family planning services without a waiver.

Sec. 803. Authority to continue providing adult day health services approved under a State Medicaid plan. Allows states to continue providing adult day health services under their state plan.

Sec. 804. State option to protect community spouses of individuals with disabilities. Clarifies States' ability to allow individuals with disabilities to remain in the community for care under home and community based care waivers.

Sec. 805. County Medicaid health insuring organizations. Amends section 9517©(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended by section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 to increase the applicable percentage to 16.

Subtitle B – Payments

Sec. 811. Payments for Puerto Rico and territories. Increases the federal funding cap for Puerto Rico and the U.S. Territories. Allows for the first time federal matching payments for improvements in data reporting systems for the Commonwealth of Puerto Rico and the U.S. Territories. These payments would not be counted against the funding limitation otherwise in effect for these areas.

Sec. 812. Medicaid drug rebate. Increases the applicable rebate on drugs by 5 percentage points.

Sec. 813. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution. Exempts extraordinary employer pension contributions from the calculation of personal income for the purposes of establishing a State's federal medical assistance percentage.

Sec. 814. Moratorium on certain payment restrictions. Protects access to care for children with disabilities who receive health care services in schools and children with disabilities who require rehabilitation services.

Sec. 815. Tennessee DSH. Provides a permanent allotment of disproportionate share

hospital funding under section 1923 of \$30 million.

Sec. 816. Clarification permitting regional medical center to participate in other States' Medicaid financing mechanism. Clarifies a regional medical center's eligibility to receive funds from a center located in another state.

Subtitle C – Miscellaneous

Sec. 821. SCHIP demonstration project for employer buy-in of family coverage.

Sec. 822. Diabetes grants. Extends diabetes grant funding until 2009.

Sec. 823. Technical correction. Makes a technical correction to provisions enacted in the Deficit Reduction Act.

TITLE XI -- MISCELLANEOUS

Sec. 901. Medicare Payment Advisory Commission status. Clarifies that MedPAC is a Congressional support agency.

Sec. 902. Repeal of trigger provision. Repeals provision created in the Medicare Modernization Act of 2003 to limit the amount of general revenues used to finance Medicare.

Sec. 903. Repeal of comparative cost adjustment program. Repeals the premium support demonstration created in the Medicare Modernization Act.

Sec. 904. Comparative effectiveness research. Establishes within the Agency of Healthcare Research and Quality a Center for Comparative Effectiveness Research to conduct research on the outcomes, effectiveness, and appropriateness of health care services. Also establishes an independent Comparative Effectiveness Research Commission to set priorities and ensure credibility for the Center's work. It also establishes a Comparative Effectiveness Research Trust Fund, initially funded through the Medicare trust fund, to support the work of the Center and the Commission.

Sec. 905. Implementation of health information technology (IT) under Medicare. Requires CMS to develop a plan to implement a health information technology system for Medicare.

Sec. 906. Development, Reporting, and use of health care measures. Requires the Secretary to designate a single national entity to coordinate development of health care measures

Sec. 907. Improvements to the Medigap Program. Directs the Secretary to implement the changes in the model law and regulations as recommended by the National Association of Insurance Commissioners in March 2007. Requires plans to offer guaranteed issue policies, and eliminates the only two statutorily mandated plans.

TITLE X -- REVENUES

Sec. 1001. Increase in rate of excise taxes on tobacco products and cigarette papers and tubes. Increases the per pack cigarette excise tax by \$0.45 and generally increases other tobacco products by a proportionate percentage. Equalizes the rate on small cigars and small cigarettes, increases the cap on large cigars to \$1.00 a cigar, and expands the definition of roll-your-own tobacco. Imposes a tax on floor stocks.

Sec. 1002. Exemption for emergency medical services transportation. Exempts from fuel excise taxes any liquid used by ambulances to provide emergency medical services.





(Original Signature of Member)

110TH CONGRESS
1ST SESSION

H. R. _____

To amend titles XVIII, XIX, and XXI of the Social Security Act to extend and improve the children's health insurance program, to improve beneficiary protections under the Medicare, Medicaid, and the CHIP program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. DINGELL (for himself, Mr. RANGEL, Mr. STARK, and Mr. PALLONE) introduced the following bill; which was referred to the Committee on

A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to extend and improve the children's health insurance program, to improve beneficiary protections under the Medicare, Medicaid, and the CHIP program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Children's Health and Medicare Protection Act of 2007”.

1 (b) TABLE OF CONTENTS.—The table of contents of
2 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—CHILDREN'S HEALTH INSURANCE PROGRAM

Sec. 100. Purpose.

Subtitle A—Funding

Sec. 101. Establishment of new base CHIP allotments.

Sec. 102. 2-year initial availability of CHIP allotments.

Sec. 103. Redistribution of unused allotments to address State funding shortfalls.

Sec. 104. Extension of option for qualifying States.

Subtitle B—Improving Enrollment and Retention of Eligible Children

Sec. 111. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts.

Sec. 112. State option to rely on findings from an express lane agency to conduct simplified eligibility determinations.

Sec. 113. Application of medicaid outreach procedures to all children and pregnant women.

Sec. 114. Encouraging culturally appropriate enrollment and retention practices.

Subtitle C—Coverage

Sec. 121. Ensuring child-centered coverage.

Sec. 122. Improving benchmark coverage options.

Sec. 123. Premium grace period.

Subtitle D—Populations

Sec. 131. Optional coverage of older children under Medicaid and CHIP.

Sec. 132. Optional coverage of legal immigrants under the Medicaid program and CHIP.

Sec. 133. State option to expand or add coverage of certain pregnant women under CHIP.

Sec. 134. Limitation on waiver authority to cover adults.

Subtitle E—Access

Sec. 141. Children's Access, Payment, and Equality Commission.

Sec. 142. Model of Interstate coordinated enrollment and coverage process.

Sec. 143. Medicaid citizenship documentation requirements.

Sec. 144. Access to dental care for children.

Sec. 145. Prohibiting initiation of new health opportunity account demonstration programs.

Subtitle F—Quality and Program Integrity

Sec. 151. Pediatric health quality measurement program.

Sec. 152. Application of certain managed care quality safeguards to CHIP.

Sec. 153. Updated Federal evaluation of CHIP.

- Sec. 154. Access to records for IG and GAO audits and evaluations.
- Sec. 155. References to title XXI.
- Sec. 156. Reliance on law; exception for State legislation.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improvements in Benefits

- Sec. 201. Coverage and waiver of cost-sharing for preventive services.
- Sec. 202. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.
- Sec. 203. Parity for mental health coinsurance.

Subtitle B—Improving, Clarifying, and Simplifying Financial Assistance for Low Income Medicare Beneficiaries

- Sec. 211. Improving assets tests for Medicare Savings Program and low-income subsidy program.
- Sec. 212. Making QI program permanent and expanding eligibility.
- Sec. 213. Eliminating barriers to enrollment.
- Sec. 214. Eliminating application of estate recovery.
- Sec. 215. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals.
- Sec. 216. Exemptions from income and resources for determination of eligibility for low-income subsidy.
- Sec. 217. Cost-sharing protections for low-income subsidy-eligible individuals.
- Sec. 218. Intelligent assignment in enrollment.

Subtitle C—Part D Beneficiary Improvements

- Sec. 221. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out of pocket threshold under Part D.
- Sec. 222. Permitting mid-year changes in enrollment for formulary changes adversely impact an enrollee.
- Sec. 223. Removal of exclusion of benzodiazepines from required coverage under the Medicare prescription drug program.
- Sec. 224. Permitting updating drug compendia under part D using part B update process.
- Sec. 225. Codification of special protections for six protected drug classifications.
- Sec. 226. Elimination of Medicare part D late enrollment penalties paid by low-income subsidy-eligible individuals.
- Sec. 227. Special enrollment period for subsidy eligible individuals.

Subtitle D—Reducing Health Disparities

- Sec. 231. Medicare data on race, ethnicity, and primary language.
- Sec. 232. Ensuring effective communication in Medicare.
- Sec. 233. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services.
- Sec. 234. Demonstration to improve care to previously uninsured.
- Sec. 235. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare.
- Sec. 236. IOM report on impact of language access services.

Sec. 237. Definitions.

TITLE III—PHYSICIANS' SERVICE PAYMENT REFORM

Sec. 301. Establishment of separate target growth rates for service categories.

Sec. 302. Improving accuracy of relative values under the Medicare physician fee schedule.

Sec. 303. Physician feedback mechanism on practice patterns.

Sec. 304. Payments for efficient physicians.

Sec. 305. Recommendations on refining the physician fee schedule.

Sec. 306. Improved and expanded medical home demonstration project.

Sec. 307. Repeal of Physician Assistance and Quality Initiative Fund.

Sec. 308. Adjustment to Medicare payment localities.

Sec. 309. Payment for imaging services.

Sec. 310. Repeal of Physicians Advisory Council.

TITLE IV—MEDICARE ADVANTAGE REFORMS

Subtitle A—Payment Reform

Sec. 401. Equalizing payments between Medicare Advantage plans and fee-for-service Medicare.

Subtitle B—Beneficiary Protections

Sec. 411. NAIC development of marketing, advertising, and related protections.

Sec. 412. Limitation on out-of-pocket costs for individual health services.

Sec. 413. MA plan enrollment modifications.

Sec. 414. Information for beneficiaries on MA plan administrative costs.

Subtitle C—Quality and Other Provisions

Sec. 421. Requiring all MA plans to meet equal standards.

Sec. 422. Development of new quality reporting measures on racial disparities.

Sec. 423. Strengthening audit authority.

Sec. 424. Improving risk adjustment for MA payments.

Sec. 425. Eliminating special treatment of private fee-for-service plans.

Sec. 426. Renaming of Medicare Advantage program.

Subtitle D—Extension of Authorities

Sec. 431. Extension and revision of authority for special needs plans (SNPs).

Sec. 432. Extension and revision of authority for Medicare reasonable cost contracts.

TITLE V—PROVISIONS RELATING TO MEDICARE PART A

Sec. 501. Inpatient hospital payment updates.

Sec. 502. Payment for inpatient rehabilitation facility (IRF) services.

Sec. 503. Long-term care hospitals.

Sec. 504. Increasing the DSH adjustment cap.

Sec. 505. PPS-exempt cancer hospitals.

Sec. 506. Skilled nursing facility payment update.

Sec. 507. Revocation of unique deeming authority of the Joint Commission for the Accreditation of Healthcare Organizations.

TITLE VI—OTHER PROVISIONS RELATING TO MEDICARE PART B

Subtitle A—Payment and Coverage Improvements

- Sec. 601. Payment for therapy services.
- Sec. 602. Medicare separate definition of outpatient speech-language pathology services.
- Sec. 603. Increased reimbursement rate for certified nurse-midwives.
- Sec. 604. Adjustment in outpatient hospital fee schedule increase factor.
- Sec. 605. Exception to 60-day limit on Medicare substitute billing arrangements in case of physicians ordered to active duty in the Armed Forces.
- Sec. 606. Excluding clinical social worker services from coverage under the medicare skilled nursing facility prospective payment system and consolidated payment.
- Sec. 607. Coverage of marriage and family therapist services and mental health counselor services.
- Sec. 608. Rental and purchase of power-driven wheelchairs.
- Sec. 609. Rental and purchase of oxygen equipment.
- Sec. 610. Adjustment for Medicare mental health services.
- Sec. 611. Extension of brachytherapy special rule.
- Sec. 612. Payment for part B drugs.

Subtitle B—Extension of Medicare Rural Access Protections

- Sec. 621. 2-year extension of floor on medicare work geographic adjustment.
- Sec. 622. 2-year extension of special treatment of certain physician pathology services under Medicare.
- Sec. 623. 2-year extension of medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.
- Sec. 624. 2-year extension of Medicare incentive payment program for physician scarcity areas .
- Sec. 625. 2-year extension of medicare increase payments for ground ambulance services in rural areas.
- Sec. 626. Extending hold harmless for small rural hospitals under the HOPD prospective payment system.

Subtitle C—End Stage Renal Disease Program

- Sec. 631. Chronic kidney disease demonstration projects.
- Sec. 632. Medicare coverage of kidney disease patient education services.
- Sec. 633. Required training for patient care dialysis technicians.
- Sec. 634. MedPAC report on treatment modalities for patients with kidney failure.
- Sec. 635. Adjustment for erythropoietin stimulating agents (ESAs).
- Sec. 636. Site neutral composite rate.
- Sec. 637. Development of ESRD bundling system and quality incentive payments.
- Sec. 638. MedPAC report on ESRD bundling system.
- Sec. 639. OIG study and report on erythropoietin.

Subtitle D—Miscellaneous

- Sec. 651. Limitation on exception to the prohibition on certain physician referrals for hospitals.

TITLE VII—PROVISIONS RELATING TO MEDICARE PARTS A AND B

- Sec. 701. Home health payment update for 2008.
- Sec. 702. 2-year extension of temporary Medicare payment increase for home health services furnished in a rural area.
- Sec. 703. Extension of Medicare secondary payer for beneficiaries with end stage renal disease for large group plans.
- Sec. 704. Plan for Medicare payment adjustments for never events.
- Sec. 705. Treatment of Medicare hospital reclassifications.

TITLE VIII—MEDICAID

Subtitle A—Protecting Existing Coverage

- Sec. 801. Modernizing transitional Medicaid.
- Sec. 802. Family planning services.
- Sec. 803. Authority to continue providing adult day health services approved under a State Medicaid plan.
- Sec. 804. State option to protect community spouses of individuals with disabilities.
- Sec. 805. County medicaid health insuring organizations .

Subtitle B—Payments

- Sec. 811. Payments for Puerto Rico and territories.
- Sec. 812. Medicaid drug rebate.
- Sec. 813. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.
- Sec. 814. Moratorium on certain payment restrictions.
- Sec. 815. Tennessee DSH.
- Sec. 816. Clarification treatment of regional medical center.

Subtitle C—Miscellaneous

- Sec. 821. Demonstration project for employer buy-in.
- Sec. 822. Diabetes grants.
- Sec. 823. Technical correction.

TITLE IX—MISCELLANEOUS

- Sec. 901. Medicare Payment Advisory Commission status.
- Sec. 902. Repeal of trigger provision.
- Sec. 903. Repeal of comparative cost adjustment (CCA) program.
- Sec. 904. Comparative effectiveness research.
- Sec. 905. Implementation of Health information technology (IT) under Medicare.
- Sec. 906. Development, reporting, and use of health care measures.
- Sec. 907. Improvements to the Medigap program.

TITLE X—REVENUES

- Sec. 1001. Increase in rate of excise taxes on tobacco products and cigarette papers and tubes.
- Sec. 1002. Exemption for emergency medical services transportation.

1 **TITLE I—CHILDREN’S HEALTH**
2 **INSURANCE PROGRAM**

3 **SEC. 100. PURPOSE.**

4 It is the purpose of this title to provide dependable
5 and stable funding for children’s health insurance under
6 titles XXI and XIX of the Social Security Act in order
7 to enroll all six million uninsured children who are eligible,
8 but not enrolled, for coverage today through such titles.

9 **Subtitle A—Funding**

10 **SEC. 101. ESTABLISHMENT OF NEW BASE CHIP ALLOT-**
11 **MENTS.**

12 Section 2104 of the Social Security Act (42 U.S.C.
13 1397dd) is amended—

14 (1) in subsection (a)—

15 (A) in paragraph (9), by striking “and” at
16 the end;

17 (B) in paragraph (10), by striking the pe-
18 riod at the end and inserting “; and”; and

19 (C) by adding at the end the following new
20 paragraph:

21 “(11) for fiscal year 2008 and each succeeding
22 fiscal year, the sum of the State allotments provided
23 under subsection (i) for such fiscal year.”; and

1 (2) in subsections (b)(1) and (c)(1), by striking
2 “subsection (d)” and inserting “subsections (d) and
3 (i)”; and

4 (3) by adding at the end the following new sub-
5 section:

6 “(i) ALLOTMENTS FOR STATES AND TERRITORIES
7 BEGINNING WITH FISCAL YEAR 2008.—

8 “(1) GENERAL ALLOTMENT COMPUTATION.—

9 Subject to the succeeding provisions of this sub-
10 section, the Secretary shall compute a State allot-
11 ment for each State for each fiscal year as follows:

12 “(A) FOR FISCAL YEAR 2008.—For fiscal
13 year 2008, the allotment of a State is equal to
14 the greater of—

15 “(i) the State projection (in its sub-
16 mission on forms CMS—21B and CMS—
17 37 for May 2007) of Federal payments to
18 the State under this title for such fiscal
19 year, except that, in the case of a State
20 that has enacted legislation to modify its
21 State child health plan during 2007, the
22 State may substitute its projection in its
23 submission on forms CMS—21B and
24 CMS—37 for August 2007, instead of
25 such forms for May 2007; or

1 “(ii) the allotment of the State under
2 this section for fiscal year 2007 multiplied
3 by the allotment increase factor under
4 paragraph (2) for fiscal year 2008.

5 “(B) INFLATION UPDATE FOR FISCAL
6 YEAR 2009 AND EACH SECOND SUCCEEDING FIS-
7 CAL YEAR.—For fiscal year 2009 and each sec-
8 ond succeeding fiscal year, the allotment of a
9 State is equal to the amount of the State allot-
10 ment under this paragraph for the previous fis-
11 cal year multiplied by the allotment increase
12 factor under paragraph (2) for the fiscal year
13 involved.

14 “(C) REBASING IN FISCAL YEAR 2010 AND
15 EACH SECOND SUCCEEDING FISCAL YEAR.—For
16 fiscal year 2010 and each second succeeding fis-
17 cal year, the allotment of a State is equal to the
18 Federal payments to the State that are attrib-
19 utable to (and countable towards) the total
20 amount of allotments available under this sec-
21 tion to the State (including allotments made
22 available under paragraph (3) as well as
23 amounts redistributed to the State) in the pre-
24 vious fiscal year multiplied by the allotment in-

1 crease factor under paragraph (2) for the fiscal
2 year involved.

3 “(D) SPECIAL RULES FOR TERRITORIES.—
4 Notwithstanding the previous subparagraphs,
5 the allotment for a State that is not one of the
6 50 States or the District of Columbia for fiscal
7 year 2008 and for a succeeding fiscal year is
8 equal to the Federal payments provided to the
9 State under this title for the previous fiscal
10 year multiplied by the allotment increase factor
11 under paragraph (2) for the fiscal year involved
12 (but determined by applying under paragraph
13 (2)(B) as if the reference to ‘in the State’ were
14 a reference to ‘in the United States’).

15 “(2) ALLOTMENT INCREASE FACTOR.—The al-
16 lotment increase factor under this paragraph for a
17 fiscal year is equal to the product of the following:

18 “(A) PER CAPITA HEALTH CARE GROWTH
19 FACTOR.—1 plus the percentage increase in the
20 projected per capita amount of National Health
21 Expenditures from the calendar year in which
22 the previous fiscal year ends to the calendar
23 year in which the fiscal year involved ends, as
24 most recently published by the Secretary before
25 the beginning of the fiscal year.

1 “(B) CHILD POPULATION GROWTH FAC-
2 TOR.—1 plus the percentage increase (if any) in
3 the population of children under 19 years of
4 age in the State from July 1 in the previous fis-
5 cal year to July 1 in the fiscal year involved, as
6 determined by the Secretary based on the most
7 recent published estimates of the Bureau of the
8 Census before the beginning of the fiscal year
9 involved, plus 1 percentage point

10 “(3) PERFORMANCE-BASED SHORTFALL AD-
11 JUSTMENT.—

12 “(A) IN GENERAL.—If a State’s expendi-
13 tures under this title in a fiscal year (beginning
14 with fiscal year 2008) exceed the total amount
15 of allotments available under this section to the
16 State in the fiscal year (determined without re-
17 gard to any redistribution it receives under sub-
18 section (f) that is available for expenditure dur-
19 ing such fiscal year, but including any carryover
20 from a previous fiscal year) and if the average
21 monthly unduplicated number of children en-
22 rolled under the State plan under this title (in-
23 cluding children receiving health care coverage
24 through funds under this title pursuant to a
25 waiver under section 1115) during such fiscal

year exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year, the allotment under this section for the State for the subsequent fiscal year (or, pursuant to subparagraph (F), for the fiscal year involved) shall be increased by the product of—

“(i) the amount by which such average monthly caseload exceeds such target number of enrollees; and

“(ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the original fiscal year involved), multiplied by the enhanced FMAP (as defined in section 2105(b)) for the State and fiscal year involved

“(B) TARGET AVERAGE NUMBER OF CHILD ENROLLEES.—In this subsection, the target average number of child enrollees for a State—

“(i) for fiscal year 2008 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this title (including such children receiving health care coverage

through funds under this title pursuant to a waiver under section 1115) during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

“(ii) for a subsequent fiscal year is equal to the target average number of child enrollees for the State for the previous fiscal year increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

“(C) PROJECTED PER CAPITA EXPENDITURES.—For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

“(i) for fiscal year 2008 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the

average monthly caseload for purposes of this paragraph during fiscal year 2007, increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for 2008; or

“(ii) for a subsequent fiscal year is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

“(D) AVAILABILITY.—Notwithstanding subsection (e), an increase in allotment under this paragraph shall only be available for expenditure during the fiscal year in which it is provided.

“(E) NO REDISTRIBUTION OF PERFORMANCE-BASED SHORTFALL ADJUSTMENT.—In no case shall any increase in allotment under this paragraph for a State be subject to redistribution to other States.

1 “(F) INTERIM ALLOTMENT ADJUST-
2 MENT.—The Secretary shall develop a process
3 to administer the performance-based shortfall
4 adjustment in a manner so it is applied to (and
5 before the end of) the fiscal year (rather than
6 the subsequent fiscal year) involved for a State
7 that the Secretary estimates will be in shortfall
8 and will exceed its enrollment target for that
9 fiscal year.

10 “(G) PERIODIC AUDITING.—The Comp-
11 troller General of the United States shall peri-
12 odically audit the accuracy of data used in the
13 computation of allotment adjustments under
14 this paragraph. Based on such audits, the
15 Comptroller General shall make such rec-
16 ommendations to the Congress and the Sec-
17 retary as the Comptroller General deems appro-
18 priate.

19 “(4) CONTINUED REPORTING.—For purposes of
20 paragraph (3) and subsection (f), the State shall
21 submit to the Secretary the State’s projected Fed-
22 eral expenditures, even if the amount of such ex-
23 penditures exceeds the total amount of allotments
24 available to the State in such fiscal year.”.

1 **SEC. 102. 2-YEAR INITIAL AVAILABILITY OF CHIP ALLOT-**
2 **MENTS.**

3 Section 2104(e) of the Social Security Act (42 U.S.C.
4 1397dd(e)) is amended to read as follows:

5 “(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

6 “(1) IN GENERAL.—Except as provided in para-
7 graph (2) and subsection (i)(3)(D), amounts allotted
8 to a State pursuant to this section—

9 “(A) for each of fiscal years 1998 through
10 2007, shall remain available for expenditure by
11 the State through the end of the second suc-
12 ceeding fiscal year; and

13 “(B) for fiscal year 2008 and each fiscal
14 year thereafter, shall remain available for ex-
15 penditure by the State through the end of the
16 succeeding fiscal year.

17 “(2) AVAILABILITY OF AMOUNTS REDISTRIB-
18 UTED.—Amounts redistributed to a State under sub-
19 section (f) shall be available for expenditure by the
20 State through the end of the fiscal year in which
21 they are redistributed, except that funds so redis-
22 tributed to a State that are not expended by the end
23 of such fiscal year shall remain available after the
24 end of such fiscal year and shall be available in the
25 following fiscal year for subsequent redistribution
26 under such subsection.”.

1 **SEC. 103. REDISTRIBUTION OF UNUSED ALLOTMENTS TO**
2 **ADDRESS STATE FUNDING SHORTFALLS.**

3 Section 2104(f) of the Social Security Act (42 U.S.C.
4 1397dd(f)) is amended—

5 (1) by striking “The Secretary” and inserting
6 the following:

7 “(1) IN GENERAL.—The Secretary”;

8 (2) by striking “States that have fully expended
9 the amount of their allotments under this section.”
10 and inserting “States that the Secretary determines
11 with respect to the fiscal year for which unused al-
12 lotments are available for redistribution under this
13 subsection, are shortfall States described in para-
14 graph (2) for such fiscal year, but not to exceed the
15 amount of the shortfall described in paragraph
16 (2)(A) for each such State (as may be adjusted
17 under paragraph (2)(C)). The amount of allotments
18 not expended or redistributed under the previous
19 sentence shall remain available for redistribution in
20 the succeeding fiscal year.”; and

21 (3) by adding at the end the following new
22 paragraph:

23 “(2) SHORTFALL STATES DESCRIBED.—

24 “(A) IN GENERAL.—For purposes of para-
25 graph (1), with respect to a fiscal year, a short-
26 fall State described in this subparagraph is a

1 State with a State child health plan approved
2 under this title for which the Secretary esti-
3 mates on the basis of the most recent data
4 available to the Secretary, that the projected ex-
5 penditures under such plan for the State for the
6 fiscal year will exceed the sum of—

7 “(i) the amount of the State’s allot-
8 ments for any preceding fiscal years that
9 remains available for expenditure and that
10 will not be expended by the end of the im-
11 mediately preceding fiscal year;

12 “(ii) the amount (if any) of the per-
13 formance based adjustment under sub-
14 section (i)(3)(A); and

15 “(iii) the amount of the State’s allot-
16 ment for the fiscal year.

17 “(B) PRORATION RULE.—If the amounts
18 available for redistribution under paragraph (1)
19 for a fiscal year are less than the total amounts
20 of the estimated shortfalls determined for the
21 year under subparagraph (A), the amount to be
22 redistributed under such paragraph for each
23 shortfall State shall be reduced proportionally.

24 “(C) RETROSPECTIVE ADJUSTMENT.—The
25 Secretary may adjust the estimates and deter-

1 minations made under paragraph (1) and this
2 paragraph with respect to a fiscal year as nec-
3 essary on the basis of the amounts reported by
4 States not later than November 30 of the suc-
5 ceeding fiscal year, as approved by the Sec-
6 retary.”.

7 **SEC. 104. EXTENSION OF OPTION FOR QUALIFYING STATES.**

8 Section 2105(g)(1)(A) of the Social Security Act (42
9 U.S.C. 1397ee(g)(1)(A)) is amended by inserting after “or
10 2007” the following: “or 30 percent of any allotment
11 under section 2104 for any subsequent fiscal year”.

12 **Subtitle B—Improving Enrollment**
13 **and Retention of Eligible Children**

14 **SEC. 111. CHIP PERFORMANCE BONUS PAYMENT TO OFF-**
15 **SET ADDITIONAL ENROLLMENT COSTS RE-**
16 **SULTING FROM ENROLLMENT AND RETEN-**
17 **TION EFFORTS.**

18 Section 2105(a) of the Social Security Act (42 U.S.C.
19 1397ee(a)) is amended by adding at the end the following
20 new paragraphs:

21 “(3) PERFORMANCE BONUS PAYMENT TO OFF-
22 SET ADDITIONAL MEDICAID AND CHIP CHILD EN-
23 ROLLMENT COSTS RESULTING FROM ENROLLMENT
24 AND RETENTION EFFORTS.—

“(A) IN GENERAL.—In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2008) the Secretary shall pay to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

“(B) AMOUNT.—The amount described in this subparagraph for a State for a fiscal year is equal to the sum of the following amounts:

“(i) FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—

“(I) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year multiplied by 35 percent of the projected per capita State Medicaid expenditures (as determined

1 under subparagraph (D)(i) for the
2 State and fiscal year under title XIX.

3 “(II) SECOND TIER ABOVE BASE-
4 LINE MEDICAID ENROLLEES.—An
5 amount equal to the number of second
6 tier above baseline child enrollees (as
7 determined under subparagraph
8 (C)(ii)) under title XIX for the State
9 and fiscal year multiplied by 90 per-
10 cent of the projected per capita State
11 Medicaid expenditures (as determined
12 under subparagraph (D)(i)) for the
13 State and fiscal year under title XIX.

14 “(ii) FOR ABOVE BASELINE CHIP EN-
15 ROLLMENT COSTS.—

16 “(I) FIRST TIER ABOVE BASE-
17 LINE CHIP ENROLLEES.—An amount
18 equal to the number of first tier above
19 baseline child enrollees under this title
20 (as determined under subparagraph
21 (C)(i)) for the State and fiscal year
22 multiplied by 5 percent of the pro-
23 jected per capita State CHIP expendi-
24 tures (as determined under subpara-

1 graph (D)(ii)) for the State and fiscal
2 year under this title.

3 “(II) SECOND TIER ABOVE BASE-
4 LINE CHIP ENROLLEES.—An amount
5 equal to the number of second tier
6 above baseline child enrollees under
7 this title (as determined under sub-
8 paragraph (C)(ii)) for the State and
9 fiscal year multiplied by 75 percent of
10 the projected per capita State CHIP
11 expenditures (as determined under
12 subparagraph (D)(ii)) for the State
13 and fiscal year under this title.

14 “(C) NUMBER OF FIRST AND SECOND TIER
15 ABOVE BASELINE CHILD ENROLLEES; BASELINE
16 NUMBER OF CHILD ENROLLEES.—For purposes
17 of this paragraph:

18 “(i) FIRST TIER ABOVE BASELINE
19 CHILD ENROLLEES.—The number of first
20 tier above baseline child enrollees for a
21 State for a fiscal year under this title or
22 title XIX is equal to the number (if any,
23 as determined by the Secretary) by
24 which—

1 “(I) the monthly average
2 unduplicated number of qualifying
3 children (as defined in subparagraph
4 (E)) enrolled during the fiscal year
5 under the State child health plan
6 under this title or under the State
7 plan under title XIX, respectively; ex-
8 ceeds

9 “(II) the baseline number of en-
10 rollees described in clause (iii) for the
11 State and fiscal year under this title
12 or title XIX, respectively;

13 but not to exceed 3 percent (in the case of
14 title XIX) or 7.5 percent (in the case of
15 this title) of the baseline number of enroll-
16 ees described in subclause (II).

17 “(ii) SECOND TIER ABOVE BASELINE
18 CHILD ENROLLEES.—The number of sec-
19 ond tier above baseline child enrollees for
20 a State for a fiscal year under this title or
21 title XIX is equal to the number (if any,
22 as determined by the Secretary) by
23 which—

24 “(I) the monthly average
25 unduplicated number of qualifying

1 children (as defined in subparagraph
2 (E)) enrolled during the fiscal year
3 under this title or under title XIX, re-
4 spectively, as described in clause
5 (i)(I); exceeds

6 “(II) the sum of the baseline
7 number of child enrollees described in
8 clause (iii) for the State and fiscal
9 year under this title or title XIX, re-
10 spectively, as described in clause
11 (i)(II), and the maximum number of
12 first tier above baseline child enrollees
13 for the State and fiscal year under
14 this title or title XIX, respectively, as
15 determined under clause (i).

16 “(iii) BASELINE NUMBER OF CHILD
17 ENROLLEES.—The baseline number of
18 child enrollees for a State under this title
19 or title XIX—

20 “(I) for fiscal year 2008 is equal
21 to the monthly average unduplicated
22 number of qualifying children enrolled
23 in the State child health plan under
24 this title or in the State plan under
25 title XIX, respectively, during fiscal

year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

“(II) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under this title or title XIX, respectively, increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

“(D) PROJECTED PER CAPITA STATE EXPENDITURES.—For purposes of subparagraph (B)—

“(i) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—The projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal fi-

1 nancial participation) for children under
2 the State plan under such title, including
3 under waivers but not including such chil-
4 dren eligible for assistance by virtue of the
5 receipt of benefits under title XVI, for the
6 most recent fiscal year for which actual
7 data are available (as determined by the
8 Secretary), increased (for each subsequent
9 fiscal year up to and including the fiscal
10 year involved) by the annual percentage in-
11 crease in per capita amount of National
12 Health Expenditures (as estimated by the
13 Secretary) for the calendar year in which
14 the respective subsequent fiscal year ends
15 and multiplied by a State matching per-
16 centage equal to 100 percent minus the
17 Federal medical assistance percentage (as
18 defined in section 1905(b)) for the fiscal
19 year involved.

20 “(ii) PROJECTED PER CAPITA STATE
21 CHIP EXPENDITURES.—The projected per
22 capita State CHIP expenditures for a
23 State and fiscal year under this title is
24 equal to the average per capita expendi-
25 tures (including both State and Federal fi-

nancial participation) for children under the State child health plan under this title, including under waivers, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the enhanced FMAP (as defined in section 2105(b)) for the fiscal year involved.

“(E) QUALIFYING CHILDREN DEFINED.—

For purposes of this subsection, the term ‘qualifying children’ means, with respect to this title or title XIX, children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2007, for enrollment under this title or title XIX, respectively, taking into account criteria applied as of such date under

1 this title or title XIX, respectively, pursuant to
2 a waiver under section 1115.

3 “(4) ENROLLMENT AND RETENTION PROVI-
4 SIONS FOR CHILDREN.— For purposes of paragraph
5 (3)(A), a State meets the condition of this para-
6 graph for a fiscal year if it is implementing at least
7 4 of the following enrollment and retention provi-
8 sions (treating each subparagraph as a separate en-
9 rollment and retention provision) throughout the en-
10 tire fiscal year:

11 “(A) CONTINUOUS ELIGIBILITY.—The
12 State has elected the option of continuous eligi-
13 bility for a full 12 months for all children de-
14 scribed in section 1902(e)(12) under title XIX
15 under 19 years of age, as well as applying such
16 policy under its State child health plan under
17 this title.

18 “(B) LIBERALIZATION OF ASSET REQUIRE-
19 MENTS.—The State meets the requirement
20 specified in either of the following clauses:

21 “(i) ELIMINATION OF ASSET TEST.—
22 The State does not apply any asset or re-
23 source test for eligibility for children under
24 title XIX or this title.

“(ii) ADMINISTRATIVE VERIFICATION
OF ASSETS.—The State—

“(I) permits a parent or care-
taker relative who is applying on be-
half of a child for medical assistance
under title XIX or child health assist-
ance under this title to declare and
certify by signature under penalty of
perjury information relating to family
assets for purposes of determining
and redetermining financial eligibility;
and

“(II) takes steps to verify assets
through means other than by requir-
ing documentation from parents and
applicants except in individual cases
of discrepancies or where otherwise
justified.

“(C) ELIMINATION OF IN-PERSON INTER-
VIEW REQUIREMENT.—The State does not re-
quire an application of a child for medical as-
sistance under title XIX (or for child health as-
sistance under this title), including an applica-
tion for renewal of such assistance, to be made
in person nor does the State require a face-to-

1 face interview, unless there are discrepancies or
2 individual circumstances justifying an in-person
3 application or face-to-face interview.

4 “(D) USE OF JOINT APPLICATION FOR
5 MEDICAID AND CHIP.—The application form
6 and supplemental forms (if any) and informa-
7 tion verification process is the same for pur-
8 poses of establishing and renewing eligibility for
9 children for medical assistance under title XIX
10 and child health assistance under this title.

11 “(E) AUTOMATIC RENEWAL (USE OF AD-
12 MINISTRATIVE RENEWAL).—

13 “(i) IN GENERAL.—The State pro-
14 vides, in the case of renewal of a child’s
15 eligibility for medical assistance under title
16 XIX or child health assistance under this
17 title, a pre-printed form completed by the
18 State based on the information available to
19 the State and notice to the parent or care-
20 taker relative of the child that eligibility of
21 the child will be renewed and continued
22 based on such information unless the State
23 is provided other information. Nothing in
24 this clause shall be construed as preventing
25 a State from verifying, through electronic

1 and other means, the information so pro-
2 vided.

3 “(ii) SATISFACTION THROUGH DEM-
4 ONSTRATED USE OF EX PARTE PROCESS.—
5 A State shall be treated as satisfying the
6 requirement of clause (i) if renewal of eli-
7 gibility of children under title XIX or this
8 title is determined without any require-
9 ment for an in-person interview, unless
10 sufficient information is not in the State’s
11 possession and cannot be acquired from
12 other sources (including other State agen-
13 cies) without the participation of the appli-
14 cant or the applicant’s parent or caretaker
15 relative.

16 “(F) PRESUMPTIVE ELIGIBILITY FOR
17 CHILDREN.—The State is implementing section
18 1920A under title XIX as well as, pursuant to
19 section 2107(e)(1), under this title .

20 “(G) EXPRESS LANE.—The State is imple-
21 menting the option described in section
22 1902(e)(13) under title XIX as well as, pursu-
23 ant to section 2107(e)(1), under this title.”.

1 **SEC. 112. STATE OPTION TO RELY ON FINDINGS FROM AN**
2 **EXPRESS LANE AGENCY TO CONDUCT SIM-**
3 **PLIFIED ELIGIBILITY DETERMINATIONS.**

4 (a) MEDICAID.—Section 1902(e) of the Social Secu-
5 rity Act (42 U.S.C. 1396a(e)) is amended by adding at
6 the end the following:

7 “(13) EXPRESS LANE OPTION.—

8 “(A) IN GENERAL.—

9 “(i) OPTION TO USE A FINDING FROM AN
10 EXPRESS LANE AGENCY.—At the option of the
11 State, the State plan may provide that in deter-
12 mining eligibility under this title for a child (as
13 defined in subparagraph (F)), the State may
14 rely on a finding made within a reasonable pe-
15 riod (as determined by the State) from an Ex-
16 press Lane agency (as defined in subparagraph
17 (E)) when it determines whether a child satis-
18 fies one or more components of eligibility for
19 medical assistance under this title. The State
20 may rely on a finding from an Express Lane
21 agency notwithstanding sections
22 1902(a)(46)(B), 1903(x), and 1137(d) and any
23 differences in budget unit, disregard, deeming
24 or other methodology, if the following require-
25 ments are met:

1 “(I) PROHIBITION ON DETERMINING
2 CHILDREN INELIGIBLE FOR COVERAGE.—

3 If a finding from an Express Lane agency
4 would result in a determination that a
5 child does not satisfy an eligibility require-
6 ment for medical assistance under this title
7 and for child health assistance under title
8 XXI, the State shall determine eligibility
9 for assistance using its regular procedures.

10 “(II) NOTICE REQUIREMENT.—For
11 any child who is found eligible for medical
12 assistance under the State plan under this
13 title or child health assistance under title
14 XXI and who is subject to premiums based
15 on an Express Lane agency’s finding of
16 such child’s income level, the State shall
17 provide notice that the child may qualify
18 for lower premium payments if evaluated
19 by the State using its regular policies and
20 of the procedures for requesting such an
21 evaluation.

22 “(III) COMPLIANCE WITH SCREEN
23 AND ENROLL REQUIREMENT.—The State
24 shall satisfy the requirements under (A)
25 and (B) of section 2102(b)(3) (relating to

1 screen and enroll) before enrolling a child
2 in child health assistance under title XXI.
3 At its option, the State may fulfill such re-
4 quirements in accordance with either op-
5 tion provided under subparagraph (C) of
6 this paragraph.

7 “(ii) OPTION TO APPLY TO RENEWALS AND
8 REDETERMINATIONS.— The State may apply
9 the provisions of this paragraph when con-
10 ducting initial determinations of eligibility, re-
11 determinations of eligibility, or both, as de-
12 scribed in the State plan.

13 “(B) RULES OF CONSTRUCTION.—Nothing in
14 this paragraph shall be construed—

15 “(i) to limit or prohibit a State from tak-
16 ing any actions otherwise permitted under this
17 title or title XXI in determining eligibility for
18 or enrolling children into medical assistance
19 under this title or child health assistance under
20 title XXI; or

21 “(ii) to modify the limitations in section
22 1902(a)(5) concerning the agencies that may
23 make a determination of eligibility for medical
24 assistance under this title.

1 “(C) OPTIONS FOR SATISFYING THE SCREEN
2 AND ENROLL REQUIREMENT.—

3 “(i) IN GENERAL.—With respect to a child
4 whose eligibility for medical assistance under
5 this title or for child health assistance under
6 title XXI has been evaluated by a State agency
7 using an income finding from an Express Lane
8 agency, a State may carry out its duties under
9 subparagraphs (A) and (B) of section
10 2102(b)(3) (relating to screen and enroll) in ac-
11 cordance with either clause (ii) or clause (iii).

12 “(ii) ESTABLISHING A SCREENING
13 THRESHOLD.—

14 “(I) IN GENERAL.—Under this clause,
15 the State establishes a screening threshold
16 set as a percentage of the Federal poverty
17 level that exceeds the highest income
18 threshold applicable under this title to the
19 child by a minimum of 30 percentage
20 points or, at State option, a higher number
21 of percentage points that reflects the value
22 (as determined by the State and described
23 in the State plan) of any differences be-
24 tween income methodologies used by the
25 program administered by the Express Lane

1 agency and the methodologies used by the
2 State in determining eligibility for medical
3 assistance under this title.

4 “(II) CHILDREN WITH INCOME NOT
5 ABOVE THRESHOLD.—If the income of a
6 child does not exceed the screening thresh-
7 old, the child is deemed to satisfy the in-
8 come eligibility criteria for medical assist-
9 ance under this title regardless of whether
10 such child would otherwise satisfy such cri-
11 teria.

12 “(III) CHILDREN WITH INCOME
13 ABOVE THRESHOLD.—If the income of a
14 child exceeds the screening threshold, the
15 child shall be considered to have an income
16 above the Medicaid applicable income level
17 described in section 2110(b)(4) and to sat-
18 isfy the requirement under section
19 2110(b)(1)(C) (relating to the requirement
20 that CHIP matching funds be used only
21 for children not eligible for Medicaid). If
22 such a child is enrolled in child health as-
23 sistance under title XXI, the State shall
24 provide the parent, guardian, or custodial
25 relative with the following:

1 “(aa) Notice that the child may
2 be eligible to receive medical assist-
3 ance under the State plan under this
4 title if evaluated for such assistance
5 under the State’s regular procedures
6 and notice of the process through
7 which a parent, guardian, or custodial
8 relative can request that the State
9 evaluate the child’s eligibility for med-
10 ical assistance under this title using
11 such regular procedures.

12 “(bb) A description of differences
13 between the medical assistance pro-
14 vided under this title and child health
15 assistance under title XXI, including
16 differences in cost-sharing require-
17 ments and covered benefits.

18 “(iii) TEMPORARY ENROLLMENT IN CHIP
19 PENDING SCREEN AND ENROLL.—

20 “(I) IN GENERAL.—Under this clause,
21 a State enrolls a child in child health as-
22 sistance under title XXI for a temporary
23 period if the child appears eligible for such
24 assistance based on an income finding by
25 an Express Lane agency.

1 “(II) DETERMINATION OF ELIGI-
2 BILITY.—During such temporary enroll-
3 ment period, the State shall determine the
4 child’s eligibility for child health assistance
5 under title XXI or for medical assistance
6 under this title in accordance with this
7 clause.

8 “(III) PROMPT FOLLOW UP.—In mak-
9 ing such a determination, the State shall
10 take prompt action to determine whether
11 the child should be enrolled in medical as-
12 sistance under this title or child health as-
13 sistance under title XXI pursuant to sub-
14 paragraphs (A) and (B) of section
15 2102(b)(3) (relating to screen and enroll).

16 “(IV) REQUIREMENT FOR SIMPLIFIED
17 DETERMINATION.—In making such a de-
18 termination, the State shall use procedures
19 that, to the maximum feasible extent, re-
20 duce the burden imposed on the individual
21 of such determination. Such procedures
22 may not require the child’s parent, guard-
23 ian, or custodial relative to provide or
24 verify information that already has been
25 provided to the State agency by an Ex-

1 press Lane agency or another source of in-
2 formation unless the State agency has rea-
3 son to believe the information is erroneous.

4 “(V) AVAILABILITY OF CHIP MATCH-
5 ING FUNDS DURING TEMPORARY ENROLL-
6 MENT PERIOD.—Medical assistance for
7 items and services that are provided to a
8 child enrolled in title XXI during a tem-
9 porary enrollment period under this clause
10 shall be treated as child health assistance
11 under such title.

12 “(D) OPTION FOR AUTOMATIC ENROLLMENT.—

13 “(i) IN GENERAL.— At its option, a State
14 may initiate an evaluation of an individual’s eli-
15 gibility for medical assistance under this title
16 without an application and determine the indi-
17 vidual’s eligibility for such assistance using
18 findings from one or more Express Lane agen-
19 cies and information from sources other than a
20 child, if the requirements of clauses (ii) and (iii)
21 are met.

22 “(ii) INDIVIDUAL CHOICE REQUIRE-
23 MENT.—The requirement of this clause is that
24 the child is enrolled in medical assistance under
25 this title or child health assistance under title

1 XXI only if the child (or a parent, caretaker
2 relative, or guardian on the behalf of the child)
3 has affirmatively assented to such enrollment.

4 “(iii) INFORMATION REQUIREMENT.—The
5 requirement of this clause is that the State in-
6 forms the parent, guardian, or custodial relative
7 of the child of the services that will be covered,
8 appropriate methods for using such services,
9 premium or other cost sharing charges (if any)
10 that apply, medical support obligations (under
11 section 1912(a)) created by enrollment (if appli-
12 cable), and the actions the parent, guardian, or
13 relative must take to maintain enrollment and
14 renew coverage.

15 “(E) EXPRESS LANE AGENCY DEFINED.—In
16 this paragraph, the term ‘express lane agency’
17 means an agency that meets the following require-
18 ments:

19 “(i) The agency determines eligibility for
20 assistance under the Food Stamp Act of 1977,
21 the Richard B. Russell National School Lunch
22 Act, the Child Nutrition Act of 1966, or the
23 Child Care and Development Block Grant Act
24 of 1990.

1 “(ii) The agency notifies the child (or a
2 parent, caretaker relative, or guardian on the
3 behalf of the child)—

4 “(I) of the information which shall be
5 disclosed;

6 “(II) that the information will be used
7 by the State solely for purposes of deter-
8 mining eligibility for and for providing
9 medical assistance under this title or child
10 health assistance under title XXI; and

11 “(III) that the child, or parent, care-
12 taker relative, or guardian, may elect to
13 not have the information disclosed for such
14 purposes.

15 “(iii) The agency and the State agency are
16 subject to an interagency agreement limiting
17 the disclosure and use of such information to
18 such purposes.

19 “(iv) The agency is determined by the
20 State agency to be capable of making the deter-
21 minations described in this paragraph and is
22 identified in the State plan under this title or
23 title XXI.

24 For purposes of this subparagraph, the term ‘State
25 agency’ refers to the agency determining eligibility

1 for medical assistance under this title or child health
2 assistance under title XXI.

3 “(F) CHILD DEFINED.—For purposes of this
4 paragraph, the term ‘child’ means an individual
5 under 19 years of age, or, at the option of a State,
6 such higher age, not to exceed 21 years of age, as
7 the State may elect.”.

8 (b) CHIP.—Section 2107(e)(1) of such Act (42
9 U.S.C. 1397gg(e)(1)) is amended by redesignating sub-
10 paragraph (B) and succeeding subparagraphs as subpara-
11 graph (C) and succeeding subparagraphs and by inserting
12 after subparagraph (A) the following new subparagraph:

13 “(B) Section 1902(e)(13) (relating to the
14 State option to rely on findings from an Ex-
15 press Lane agency to help evaluate a child’s eli-
16 gibility for medical assistance).”.

17 (c) ELECTRONIC TRANSMISSION OF INFORMATION.—
18 Section 1902 of such Act (42 U.S.C. 1396a) is amended
19 by adding at the end the following new subsection:

20 “(dd) ELECTRONIC TRANSMISSION OF INFORMA-
21 TION.—If the State agency determining eligibility for med-
22 ical assistance under this title or child health assistance
23 under title XXI verifies an element of eligibility based on
24 information from an Express Lane Agency (as defined in
25 subsection (e)(13)(F)), or from another public agency,

1 then the applicant's signature under penalty of perjury
2 shall not be required as to such element. Any signature
3 requirement for an application for medical assistance may
4 be satisfied through an electronic signature, as defined in
5 section 1710(1) of the Government Paperwork Elimination
6 Act (44 U.S.C. 3504 note). The requirements of
7 subparagraphs (A) and (B) of section 1137(d)(2) may be
8 met through evidence in digital or electronic form.”.

9 (d) AUTHORIZATION OF INFORMATION DISCLOSURE.—
10

11 (1) IN GENERAL.—Title XIX of the Social Security
12 Act is amended—

13 (A) by redesignating section 1939 as section 1940; and
14

15 (B) by inserting after section 1938 the following new section:
16

17 **“SEC. 1939. AUTHORIZATION TO RECEIVE PERTINENT INFORMATION.**
18

19 “(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity
20 in possession of the sources of data potentially pertinent
21 to eligibility determinations under this title (including eligibility
22 files maintained by Express Lane agencies described in section 1902(e)(13)(F), information described
23 in paragraph (2) or (3) of section 1137(a), vital records
24
25

1 information about births in any State, and information de-
2 scribed in sections 453(i) and 1902(a)(25)(I)) is author-
3 ized to convey such data or information to the State agen-
4 cy administering the State plan under this title, to the
5 extent such conveyance meets the requirements of sub-
6 section (b).

7 “(b) REQUIREMENTS FOR CONVEYANCE.—Data or
8 information may be conveyed pursuant to subsection (a)
9 only if the following requirements are met:

10 “(1) The individual whose circumstances are
11 described in the data or information (or such indi-
12 vidual’s parent, guardian, caretaker relative, or au-
13 thorized representative) has either provided advance
14 consent to disclosure or has not objected to disclo-
15 sure after receiving advance notice of disclosure and
16 a reasonable opportunity to object.

17 “(2) Such data or information are used solely
18 for the purposes of—

19 “(A) identifying individuals who are eligi-
20 ble or potentially eligible for medical assistance
21 under this title and enrolling or attempting to
22 enroll such individuals in the State plan; and

23 “(B) verifying the eligibility of individuals
24 for medical assistance under the State plan.

1 “(3) An interagency or other agreement, con-
2 sistent with standards developed by the Secretary—

3 “(A) prevents the unauthorized use, disclo-
4 sure, or modification of such data and other-
5 wise meets applicable Federal requirements
6 safeguarding privacy and data security; and

7 “(B) requires the State agency admin-
8 istering the State plan to use the data and in-
9 formation obtained under this section to seek to
10 enroll individuals in the plan.

11 “(c) CRIMINAL PENALTY.—A private entity described
12 in the subsection (a) that publishes, discloses, or makes
13 known in any manner, or to any extent not authorized by
14 Federal law, any information obtained under this section
15 shall be fined not more than \$1,000 or imprisoned not
16 more than 1 year, or both, for each such unauthorized
17 publication or disclosure.

18 “(d) RULE OF CONSTRUCTION.—The limitations and
19 requirements that apply to disclosure pursuant to this sec-
20 tion shall not be construed to prohibit the conveyance or
21 disclosure of data or information otherwise permitted
22 under Federal law (without regard to this section).”.

23 (2) CONFORMING AMENDMENT TO TITLE XXI.—
24 Section 2107(e)(1) of such Act (42 U.S.C.
25 1397gg(e)(1)), as amended by subsection (b), is

1 amended by adding at the end the following new
2 subparagraph:

3 “(F) Section 1939 (relating to authoriza-
4 tion to receive data potentially pertinent to eli-
5 gibility determinations).”.

6 (3) CONFORMING AMENDMENT TO PROVIDE AC-
7 CESS TO DATA ABOUT ENROLLMENT IN INSURANCE
8 FOR PURPOSES OF EVALUATING APPLICATIONS AND
9 FOR CHIP.—Section 1902(a)(25)(I)(i) of such Act
10 (42 U.S.C. 1396a(a)(25)(I)(i)) is amended—

11 (A) by inserting “(and, at State option, in-
12 dividuals who are potentially eligible or who
13 apply)” after “with respect to individuals who
14 are eligible”; and

15 (B) by inserting “under this title (and, at
16 State option, child health assistance under title
17 XXI)” after “the State plan”.

18 (e) EFFECTIVE DATE.—The amendments made by
19 this section are effective on January 1, 2008.

20 **SEC. 113. APPLICATION OF MEDICAID OUTREACH PROCE-**
21 **DURES TO ALL CHILDREN AND PREGNANT**
22 **WOMEN.**

23 (a) IN GENERAL.—Section 1902(a)(55) of the Social
24 Security Act (42 U.S.C. 1396a(a)(55)) is amended—

(1) in the matter before subparagraph (A), by striking “individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)” and inserting “children and pregnant women for medical assistance under any provision of this title”; and

(2) in subparagraph (B), by inserting before the semicolon at the end the following: “, which need not be the same application form for all such individuals”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on January 1, 2008.

SEC. 114. ENCOURAGING CULTURALLY APPROPRIATE ENROLLMENT AND RETENTION PRACTICES.

(a) USE OF MEDICAID FUNDS.—Section 1903(a)(2) of the Social Security Act (42 U.S.C. 1396b(a)(2)) is amended by adding at the end the following new subparagraph:

“(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment and retention under

1 this title of children of families for whom English is
2 not the primary language; plus”.

3 (b) USE OF COMMUNITY HEALTH WORKERS FOR
4 OUTREACH ACTIVITIES.—

5 (1) IN GENERAL.—Section 2102(c)(1) of such
6 Act (42 U.S.C. 1397bb(c)(1)) is amended by insert-
7 ing “(through community health workers and oth-
8 ers)” after “Outreach”.

9 (2) IN FEDERAL EVALUATION.—Section
10 2108(c)(3)(B) of such Act (42 U.S.C.
11 1397hh(c)(3)(B)) is amended by inserting “(such as
12 through community health workers and others)”
13 after “including practices”.

14 **Subtitle C—Coverage**

15 **SEC. 121. ENSURING CHILD-CENTERED COVERAGE.**

16 (a) ADDITIONAL REQUIRED SERVICES.—

17 (1) CHILD-CENTERED COVERAGE.—Section
18 2103 of the Social Security Act (42 U.S.C. 1397cc)
19 is amended—

20 (A) in subsection (a)—

21 (i) in the matter before paragraph
22 (1), by striking “subsection (c)(5)” and in-
23 serting “paragraphs (5) and (6) of sub-
24 section (c)”; and

1 (ii) in paragraph (1), by inserting “at
2 least” after “that is”; and
3 (B) in subsection (c)—

4 (i) by redesignating paragraph (5) as
5 paragraph (6); and

6 (ii) by inserting after paragraph (4),
7 the following:

8 “(5) DENTAL, FQHC, AND RHC SERVICES.—The
9 child health assistance provided to a targeted low-in-
10 come child (whether through benchmark coverage or
11 benchmark-equivalent coverage or otherwise) shall
12 include coverage of the following:

13 “(A) Dental services necessary to prevent
14 disease and promote oral health, restore oral
15 structures to health and function, and treat
16 emergency conditions.

17 “(B) Federally-qualified health center serv-
18 ices (as defined in section 1905(l)(2)) and rural
19 health clinic services (as defined in section
20 1905(l)(1)).

21 “Nothing in this section shall be construed as pre-
22 venting a State child health plan from providing
23 such services as part of benchmark coverage or in
24 addition to the benefits provided through benchmark
25 coverage.”.

(2) REQUIRED PAYMENT FOR FQHC AND RHC SERVICES.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 112(b) and 112(d)(2), is amended by inserting after subparagraph (B) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

“(C) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).”.

(3) MENTAL HEALTH PARITY.—Section 2103(a)(2)(C) of such Act (42 U.S.C. 1397aa(a)(2)(C)) is amended by inserting “(or 100 percent in the case of the category of services described in subparagraph (B) of such subsection)” after “75 percent”.

(4) EFFECTIVE DATE.—The amendments made by this subsection and subsection (d) shall apply to health benefits coverage provided on or after October 1, 2008.

(b) CLARIFICATION OF REQUIREMENT TO PROVIDE EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK BENEFIT PACKAGES UNDER MEDICAID .—

(1) IN GENERAL.—Section 1937(a)(1) of the Social Security Act (42 U.S.C. 1396u-7(a)(1)) is amended—

(A) in subparagraph (A)—

(i) in the matter before clause (i), by striking “Notwithstanding any other provision of this title” and inserting “Subject to subparagraph (E)”; and

(ii) by striking “enrollment in coverage that provides” and all that follows and inserting “benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2).”;

(B) by striking subparagraph (C) and inserting the following new subparagraph:

“(C) STATE OPTION TO PROVIDE ADDITIONAL BENEFITS.—A State, at its option, may provide such additional benefits to benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2) as the State may specify.”; and

(C) by adding at the end the following new subparagraph:

1 “(E) REQUIRING COVERAGE OF EPSDT
2 SERVICES.—Nothing in this paragraph shall be
3 construed as affecting a child’s entitlement to
4 care and services described in subsections
5 (a)(4)(B) and (r) of section 1905 and provided
6 in accordance with section 1902(a)(43) whether
7 provided through benchmark coverage, bench-
8 mark equivalent coverage, or otherwise.”.

9 (2) EFFECTIVE DATE.—The amendments made
10 by paragraph (1) shall take effect as if included in
11 the amendment made by section 6044(a) of the Def-
12 icit Reduction Act of 2005.

13 (c) CLARIFICATION OF COVERAGE OF SERVICES IN
14 SCHOOL-BASED HEALTH CENTERS INCLUDED AS CHILD
15 HEALTH ASSISTANCE.—

16 (1) IN GENERAL.—Section 2110(a)(5) of such
17 Act (42 U.S.C. 1397jj(a)(5)) is amended by insert-
18 ing after “health center services” the following: “and
19 school-based health center services for which
20 coverage is otherwise provided under this title when
21 furnished by a school-based health center that is au-
22 thorized to furnish such services under State law”.

23 (2) EFFECTIVE DATE.—The amendment made
24 by paragraph (1) shall apply to child health assist-

1 ance furnished on or after the date of the enactment
2 of this Act.

3 (d) ASSURING ACCESS TO CARE.—

4 (1) STATE CHILD HEALTH PLAN REQUIRE-
5 MENT.—Section 2102(a)(7)(B) of such Act (42
6 U.S.C. 1397bb(c)(2)) is amended by inserting “and
7 services described in section 2103(c)(5)” after
8 “emergency services”.

9 (2) REFERENCE TO EFFECTIVE DATE.—For the
10 effective date for the amendments made by this sub-
11 section, see subsection (a)(5).

12 **SEC. 122. IMPROVING BENCHMARK COVERAGE OPTIONS.**

13 (a) LIMITATION ON SECRETARY-APPROVED COV-
14 ERAGE.—

15 (1) UNDER CHIP.—Section 2103(a)(4) of the
16 Social Security Act (42 U.S.C. 1397ec(a)(4)) is
17 amended by inserting before the period at the end
18 the following: “if the health benefits coverage is at
19 least equivalent to the benefits coverage in a bench-
20 mark benefit package described in subsection (b)”.

21 (2) UNDER MEDICAID.—Section 1937(b)(1)(D)
22 of the Social Security Act (42 U.S.C. 1396u-
23 7(b)(1)(D)) is amended by inserting before the pe-
24 riod at the end the following: “if the health benefits
25 coverage is at least equivalent to the benefits cov-

1 erage in benchmark coverage described in subpara-
2 graph (A), (B), or (C)’’.

3 (b) REQUIREMENT FOR MOST POPULAR FAMILY
4 COVERAGE FOR STATE EMPLOYEE COVERAGE BENCH-
5 MARK.—

6 (1) CHIP.—Section 2103(b)(2) of such Act (42
7 U.S.C. 1397(b)(2)) is amended by inserting “and
8 that has been selected most frequently by employees
9 seeking dependent coverage, among such plans that
10 provide such dependent coverage, in either of the
11 previous 2 plan years” before the period at the end.

12 (2) MEDICAID.—Section 1937(b)(1)(B) of such
13 Act is amended by inserting “and that has been se-
14 lected most frequently, by employees seeking depend-
15 ent coverage, among such plans that provide such
16 dependent coverage, in either of the previous 2 plan
17 years” before the period at the end.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to health benefits coverage pro-
20 vided on or after October 1, 2008.

21 **SEC. 123. PREMIUM GRACE PERIOD.**

22 (a) IN GENERAL.—Section 2103(e)(3) of the Social
23 Security Act (42 U.S.C. 1397cc(e)(3)) is amended by add-
24 ing at the end the following new subparagraph:

1 “(C) PREMIUM GRACE PERIOD.—The State
2 child health plan—

3 “(i) shall afford individuals enrolled
4 under the plan a grace period of at least
5 30 days from the beginning of a new cov-
6 erage period to make premium payments
7 before the individual’s coverage under the
8 plan may be terminated; and

9 “(ii) shall provide to such an indi-
10 vidual, not later than 7 days after the first
11 day of such grace period, notice—

12 “(I) that failure to make a pre-
13 mium payment within the grace pe-
14 riod will result in termination of cov-
15 erage under the State child health
16 plan; and

17 “(II) of the individual’s right to
18 challenge the proposed termination
19 pursuant to the applicable Federal
20 regulations.

21 For purposes of clause (i), the term ‘new cov-
22 erage period’ means the month immediately fol-
23 lowing the last month for which the premium
24 has been paid.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to new coverage periods begin-
3 ning on or after January 1, 2009.

4 **Subtitle D—Populations**

5 **SEC. 131. OPTIONAL COVERAGE OF OLDER CHILDREN**
6 **UNDER MEDICAID AND CHIP.**

7 (a) MEDICAID.—

8 (1) IN GENERAL.—Section 1902(l)(1)(D) of the
9 Social Security Act (42 U.S.C. 1396a(l)(1)(D)) is
10 amended by striking “but have not attained 19 years
11 of age” and inserting “but is under 19 years of age
12 (or, at the option of a State and subject to section
13 131(d) of the Children’s Health and Medicare Pro-
14 tection Act of 2007, under such higher age, not to
15 exceed 25 years of age, as the State may elect)”.

16 (2) CONFORMING AMENDMENTS.—

17 (A) Section 1902(e)(3)(A) of such Act (42
18 U.S.C. 1396a(e)(3)(A)) is amended by striking
19 “18 years of age or younger” and inserting
20 “under 19 years of age (or under such higher
21 age as the State has elected under subsection
22 (l)(1)(D))” after “18 years of age”.

23 (B) Section 1902(e)(12) of such Act (42
24 U.S.C. 1396a(e)(12)) is amended by inserting
25 “or such higher age as the State has elected

1 under subsection (l)(1)(D)” after “19 years of
2 age”.

3 (C) Section 1905(a) of such Act (42
4 U.S.C. 1396d(a)) is amended, in clause (i), by
5 inserting “or under such higher age as the
6 State has elected under subsection (l)(1)(D)”
7 after “as the State may choose”.

8 (D) Section 1920A(b)(1) of such Act (42
9 U.S.C. 1396r-1a(b)(1)) is amended by insert-
10 ing “or under such higher age as the State has
11 elected under section 1902(l)(1)(D)” after “19
12 years of age”.

13 (E) Section 1928(h)(1) of such Act (42
14 U.S.C. 1396s(h)(1)) is amended by striking “18
15 years of age or younger” and inserting “under
16 19 years of age or under such higher age as the
17 State has elected under section 1902(l)(1)(D)”.

18 (F) Section 1932(a)(2)(A) of such Act (42
19 U.S.C. 1396u-2(a)(2)(A)) is amended by in-
20 serting “(or under such higher age as the State
21 has elected under section 1902(l)(1)(D))” after
22 “19 years of age”.

23 (b) TITLE XXI.—Section 2110(c)(1) of such Act (42
24 U.S.C. 1397jj(c)(1)) is amended by inserting “(or, at the
25 option of the State and subject to section 131(d) of the

1 Children's Health and Medicare Protection Act of 2007,
2 under such higher age as the State has elected under sec-
3 tion 1902(l)(1)(D))”.

4 (e) EFFECTIVE DATE.—Subject to subsection (d),
5 the amendments made by this section take effect on Janu-
6 ary 1, 2010.

7 (d) TRANSITION.—In carrying out the amendments
8 made by subsections (a) and (b)—

9 (1) for 2010, a State election under section
10 1902(l)(1)(D) shall only apply with respect to title
11 XXI of such Act and the age elected may not exceed
12 21 years of age;

13 (2) for 2011, a State election under section
14 1902(l)(1)(D) may apply under titles XIX and XXI
15 of such Act and the age elected may not exceed 23
16 years of age;

17 (3) for 2012, a State election under section
18 1902(l)(1)(D) may apply under titles XIX and XXI
19 of such Act and the age elected may not exceed 24
20 years of age; and

21 (4) for 2013 and each subsequent year, a State
22 election under section 1902(l)(1)(D) may apply
23 under titles XIX and XXI of such Act and the age
24 elected may not exceed 25 years of age.

1 **SEC. 132. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS**
2 **UNDER THE MEDICAID PROGRAM AND CHIP.**

3 (a) MEDICAID PROGRAM.—Section 1903(v) of the
4 Social Security Act (42 U.S.C. 1396b(v)) is amended—

5 (1) in paragraph (1), by striking “paragraph
6 (2)” and inserting “paragraphs (2) and (4)”; and

7 (2) by adding at the end the following new
8 paragraph:

9 “(4)(A) A State may elect (in a plan amendment
10 under this title) to provide medical assistance under this
11 title, notwithstanding sections 401(a), 402(b), 403, and
12 421 of the Personal Responsibility and Work Opportunity
13 Reconciliation Act of 1996, for aliens who are lawfully re-
14 siding in the United States (including battered aliens de-
15 scribed in section 431(c) of such Act) and who are other-
16 wise eligible for such assistance, within either or both of
17 the following eligibility categories:

18 “(i) PREGNANT WOMEN.—Women during preg-
19 nancy (and during the 60-day period beginning on
20 the last day of the pregnancy).

21 “(ii) CHILDREN.—Individuals under age 19 (or
22 such higher age as the State has elected under sec-
23 tion 1902(l)(1)(D)), including optional targeted low-
24 income children described in section 1905(u)(2)(B).

25 “(B) In the case of a State that has elected to provide
26 medical assistance to a category of aliens under subpara-

1 graph (A), no debt shall accrue under an affidavit of sup-
2 port against any sponsor of such an alien on the basis
3 of provision of medical assistance to such category and
4 the cost of such assistance shall not be considered as an
5 unreimbursed cost.”.

6 (b) CHIP.—Section 2107(e)(1) of such Act (42
7 U.S.C. 1397gg(e)(1)), as amended by section 112(b),
8 112(d)(2), and 121(a)(2), is amended by redesignating
9 subparagraphs (E) through (G) as subparagraphs (G)
10 through (I), respectively, and by inserting after subpara-
11 graph (D) the following new subparagraphs:

12 “(E) Section 1903(v)(4)(A) (relating to
13 optional coverage of certain categories of law-
14 fully residing immigrants), insofar as it relates
15 to the category of pregnant women described in
16 clause (i) of such section, but only if the State
17 has elected to apply such section with respect to
18 such women under title XIX and the State has
19 elected the option under section 2111 to provide
20 assistance for pregnant women under this title.

21 “(F) Section 1903(v)(4)(A) (relating to op-
22 tional coverage of categories of lawfully residing
23 immigrants), insofar as it relates to the cat-
24 egory of children described in clause (ii) of such
25 section, but only if the State has elected to

1 apply such section with respect to such children
2 under title XIX.”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section take effect on the date of the enactment of
5 this Act.

6 **SEC. 133. STATE OPTION TO EXPAND OR ADD COVERAGE**
7 **OF CERTAIN PREGNANT WOMEN UNDER**
8 **CHIP.**

9 (a) CHIP.—

10 (1) COVERAGE.—Title XXI (42 U.S.C. 1397aa
11 et seq.) of the Social Security Act is amended by
12 adding at the end the following new section:

13 **“SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-IN-**
14 **COME PREGNANT WOMEN.**

15 “(a) OPTIONAL COVERAGE.—Notwithstanding any
16 other provision of this title, a State may provide for cov-
17 erage, through an amendment to its State child health
18 plan under section 2102, of assistance for pregnant
19 women for targeted low-income pregnant women in ac-
20 cordance with this section, but only if—

21 “(1) the State has established an income eligi-
22 bility level—

23 “(A) for pregnant women, under any of
24 clauses (i)(III), (i)(IV), or (ii)(IX) of section
25 1902(a)(10)(A), that is at least 185 percent (or

1 such higher percent as the State has in effect
2 for pregnant women under this title) of the pov-
3 erty line applicable to a family of the size in-
4 volved, but in no case a percent lower than the
5 percent in effect under any such clause as of
6 July 1, 2007; and

7 “(B) for children under 19 years of age
8 under this title (or title XIX) that is at least
9 200 percent of the poverty line applicable to a
10 family of the size involved; and

11 “(2) the State does not impose, with respect to
12 the enrollment under the State child health plan of
13 targeted low-income children during the quarter, any
14 enrollment cap or other numerical limitation on en-
15 rollment, any waiting list, any procedures designed
16 to delay the consideration of applications for enroll-
17 ment, or similar limitation with respect to enroll-
18 ment.

19 “(b) DEFINITIONS.—For purposes of this title:

20 “(1) ASSISTANCE FOR PREGNANT WOMEN.—

21 The term ‘assistance for pregnant women’ has the
22 meaning given the term child health assistance in
23 section 2110(a) as if any reference to targeted low-
24 income children were a reference to targeted low-in-
25 come pregnant women.

1 “(2) TARGETED LOW-INCOME PREGNANT
2 WOMAN.—The term ‘targeted low-income pregnant
3 woman’ means a woman—

4 “(A) during pregnancy and through the
5 end of the month in which the 60-day period
6 (beginning on the last day of her pregnancy)
7 ends;

8 “(B) whose family income exceeds 185 per-
9 cent (or, if higher, the percent applied under
10 subsection (a)(1)(A)) of the poverty level appli-
11 cable to a family of the size involved, but does
12 not exceed the income eligibility level estab-
13 lished under the State child health plan under
14 this title for a targeted low-income child; and

15 “(C) who satisfies the requirements of
16 paragraphs (1)(A), (1)(C), (2), and (3) of sec-
17 tion 2110(b), applied as if any reference to a
18 child was a reference to a pregnant woman.

19 “(c) REFERENCES TO TERMS AND SPECIAL
20 RULES.—In the case of, and with respect to, a State pro-
21 viding for coverage of assistance for pregnant women to
22 targeted low-income pregnant women under subsection
23 (a), the following special rules apply:

24 “(1) Any reference in this title (other than in
25 subsection (b)) to a targeted low-income child is

1 deemed to include a reference to a targeted low-in-
2 come pregnant woman.

3 “(2) Any reference in this title to child health
4 assistance (other than with respect to the provision
5 of early and periodic screening, diagnostic, and
6 treatment services) with respect to such women is
7 deemed a reference to assistance for pregnant
8 women.

9 “(3) Any such reference (other than in section
10 2105(d)) to a child is deemed a reference to a
11 woman during pregnancy and the period described
12 in subsection (b)(2)(A).

13 “(4) In applying section 2102(b)(3)(B), any
14 reference to children found through screening to be
15 eligible for medical assistance under the State med-
16 icaid plan under title XIX is deemed a reference to
17 pregnant women.

18 “(5) There shall be no exclusion of benefits for
19 services described in subsection (b)(1) based on any
20 preexisting condition and no waiting period (includ-
21 ing any waiting period imposed to carry out section
22 2102(b)(3)(C)) shall apply.

23 “(6) In applying section 2103(e)(3)(B) in the
24 case of a pregnant woman provided coverage under
25 this section, the limitation on total annual aggregate

1 cost-sharing shall be applied to such pregnant
2 woman.

3 “(7) In applying section 2104(i)—

4 “(A) in the case of a State which did not
5 provide for coverage for pregnant women under
6 this title (under a waiver or otherwise) during
7 fiscal year 2007, the allotment amount other-
8 wise computed for the first fiscal year in which
9 the State elects to provide coverage under this
10 section shall be increased by an amount (deter-
11 mined by the Secretary) equal to the enhanced
12 FMAP of the expenditures under this title for
13 such coverage, based upon projected enrollment
14 and per capita costs of such enrollment; and

15 “(B) in the case of a State which provided
16 for coverage of pregnant women under this title
17 for the previous fiscal year—

18 “(i) in applying paragraph (2)(B) of
19 such section, there shall also be taken into
20 account (in an appropriate proportion) the
21 percentage increase in births in the State
22 for the relevant period; and

23 “(ii) in applying paragraph (3), preg-
24 nant women (and per capita expenditures
25 for such women) shall be accounted for

1 separately from children, but shall be in-
2 cluded in the total amount of any allot-
3 ment adjustment under such paragraph.

4 “(d) AUTOMATIC ENROLLMENT FOR CHILDREN
5 BORN TO WOMEN RECEIVING ASSISTANCE FOR PREG-
6 NANT WOMEN.—If a child is born to a targeted low-in-
7 come pregnant woman who was receiving assistance for
8 pregnant women under this section on the date of the
9 child’s birth, the child shall be deemed to have applied for
10 child health assistance under the State child health plan
11 and to have been found eligible for such assistance under
12 such plan or to have applied for medical assistance under
13 title XIX and to have been found eligible for such assist-
14 ance under such title on the date of such birth, based on
15 the mother’s reported income as of the time of her enroll-
16 ment under this section and applicable income eligibility
17 levels under this title and title XIX, and to remain eligible
18 for such assistance until the child attains 1 year of age.
19 During the period in which a child is deemed under the
20 preceding sentence to be eligible for child health or med-
21 ical assistance, the assistance for pregnant women or med-
22 ical assistance eligibility identification number of the
23 mother shall also serve as the identification number of the
24 child, and all claims shall be submitted and paid under

1 such number (unless the State issues a separate identifica-
2 tion number for the child before such period expires).”.

3 (2) ADDITIONAL AMENDMENT.—Section
4 2107(e)(1)(H) of such Act (42 U.S.C.
5 1397gg(e)(1)(H)), as redesignated by section
6 133(b), is amended to read as follows:

7 “(H) Sections 1920 and 1920A (relating
8 to presumptive eligibility for pregnant women
9 and children).”.

10 (b) AMENDMENTS TO MEDICAID.—

11 (1) ELIGIBILITY OF A NEWBORN.—Section
12 1902(e)(4) of the Social Security Act (42 U.S.C.
13 1396a(e)(4)) is amended in the first sentence by
14 striking “so long as the child is a member of the
15 woman’s household and the woman remains (or
16 would remain if pregnant) eligible for such assist-
17 ance”.

18 (2) APPLICATION OF QUALIFIED ENTITIES TO
19 PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN
20 UNDER MEDICAID.—Section 1920(b) of the Social
21 Security Act (42 U.S.C. 1396r–1(b)) is amended by
22 adding after paragraph (2) the following flush sen-
23 tence:

24 “The term ‘qualified provider’ also includes a qualified en-
25 tity, as defined in section 1920A(b)(3).”.

1 **SEC. 134. LIMITATION ON WAIVER AUTHORITY TO COVER**
2 **ADULTS.**

3 Section 2102 of the Social Security Act (42 U.S.C.
4 1397bb) is amended by adding at the end the following
5 new subsection:

6 “(d) **LIMITATION ON COVERAGE OF ADULTS.**—Not-
7 withstanding any other provision of this title, the Sec-
8 retary may not, through the exercise of any waiver author-
9 ity on or after January 1, 2008, provide for Federal finan-
10 cial participation to a State under this title for health care
11 services for individuals who are not targeted low-income
12 children or pregnant women unless the Secretary deter-
13 mines that no eligible targeted low-income child in the
14 State would be denied coverage under this title for health
15 care services because of such eligibility. In making such
16 determination, the Secretary must receive assurances
17 that—

18 “(1) there is no waiting list under this title in
19 the State for targeted low-income children to receive
20 child health assistance under this title; and

21 “(2) the State has in place an outreach pro-
22 gram to reach all targeted low-income children in
23 families with incomes less than 200 percent of the
24 poverty line.”.

Subtitle E—Access

SEC. 141. CHILDREN'S ACCESS, PAYMENT, AND EQUALITY COMMISSION.

Title XIX of the Social Security Act is amended by inserting before section 1901 the following new section:

“CHILDREN’S ACCESS, PAYMENT, AND EQUALITY

COMMISSION

“SEC. 1900. (a) ESTABLISHMENT.—There is hereby established as an agency of Congress the Children’s Access, Payment, and Equality Commission (in this section referred to as the ‘Commission’).

“(b) DUTIES.—

“(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

“(A) review Federal and State payment policies of the Medicaid program established under this title (in this section referred to as ‘Medicaid’) and the State Children’s Health Insurance Program established under title XXI (in this section referred to as ‘CHIP’), including topics described in paragraph (2);

“(B) review access to, and affordability of, coverage and services for enrollees under Medicaid and CHIP;

1 “(C) make recommendations to Congress
2 concerning such policies;

3 “(D) by not later than March 1 of each
4 year, submit to Congress a report containing
5 the results of such reviews and its recommenda-
6 tions concerning such policies; and

7 “(E) by not later than June 1 of each
8 year, submit to Congress a report containing an
9 examination of issues affecting Medicaid and
10 CHIP, including the implications of changes in
11 health care delivery in the United States and in
12 the market for health care services on such pro-
13 grams.

14 “(2) SPECIFIC TOPICS TO BE REVIEWED.—Spe-
15 cifically, the Commission shall review the following:

16 “(A) The factors affecting expenditures for
17 services in different sectors (such as physician,
18 hospital and other sectors), payment methodolo-
19 gies, and their relationship to access and qual-
20 ity of care for Medicaid and CHIP beneficiaries.

21 “(B) The impact of Federal and State
22 Medicaid and CHIP payment policies on access
23 to services (including dental services) for chil-
24 dren (including children with disabilities) and
25 other Medicaid and CHIP populations.

1 “(C) The impact of Federal and State
2 Medicaid and CHIP policies on reducing health
3 disparities, including geographic disparities and
4 disparities among minority populations.

5 “(D) The overall financial stability of the
6 health care safety net, including Federally-
7 qualified health centers, rural health centers,
8 school-based clinics, disproportionate share hos-
9 pitals, public hospitals, providers and grantees
10 under section 2612(a)(5) of the Public Health
11 Service Act (popularly known as the Ryan
12 White CARE Act), and other providers that
13 have a patient base which includes a dispropor-
14 tionate number of uninsured or low-income in-
15 dividuals and the impact of CHIP and Medicaid
16 policies on such stability.

17 “(E) The relation (if any) between pay-
18 ment rates for providers and improvement in
19 care for children as measured under the chil-
20 dren’s health quality measurement program es-
21 tablished under section 151 of the Children’s
22 Health and Medicare Protection Act of 2007.

23 “(F) The affordability, cost effectiveness,
24 and accessibility of services needed by special

1 populations under Medicaid and CHIP as com-
2 pared with private-sector coverage.

3 “(G) The extent to which the operation of
4 Medicaid and CHIP ensures access, comparable
5 to access under employer-sponsored or other
6 private health insurance coverage (or in the
7 case of federally-qualified health center services
8 (as defined in section 1905(l)(2)) and rural
9 health clinic services (as defined in section
10 1905(l)(1)), access comparable to the access to
11 such services under title XIX), for targeted low-
12 income children.

13 “(H) The effect of demonstrations under
14 section 1115, benchmark coverage under section
15 1937, and other coverage under section 1938,
16 on access to care, affordability of coverage, pro-
17 vider ability to achieve children’s health quality
18 performance measures, and access to safety net
19 services.

20 “(3) COMMENTS ON CERTAIN SECRETARIAL RE-
21 PORTS.—If the Secretary submits to Congress (or a
22 committee of Congress) a report that is required by
23 law and that relates to payment policies under Med-
24 icaid or CHIP, the Secretary shall transmit a copy
25 of the report to the Commission. The Commission

1 shall review the report and, not later than 6 months
2 after the date of submittal of the Secretary's report
3 to Congress, shall submit to the appropriate commit-
4 tees of Congress written comments on such report.
5 Such comments may include such recommendations
6 as the Commission deems appropriate.

7 “(4) AGENDA AND ADDITIONAL REVIEWS.—The
8 Commission shall consult periodically with the
9 Chairmen and Ranking Minority Members of the ap-
10 propriate committees of Congress regarding the
11 Commission's agenda and progress towards achiev-
12 ing the agenda. The Commission may conduct addi-
13 tional reviews, and submit additional reports to the
14 appropriate committees of Congress, from time to
15 time on such topics relating to the program under
16 this title or title XXI as may be requested by such
17 Chairmen and Members and as the Commission
18 deems appropriate.

19 “(5) AVAILABILITY OF REPORTS.—The Com-
20 mission shall transmit to the Secretary a copy of
21 each report submitted under this subsection and
22 shall make such reports available to the public.

23 “(6) APPROPRIATE COMMITTEE OF CON-
24 GRESS.—For purposes of this section, the term ‘ap-
25 propriate committees of Congress’ means the Com-

1 mittees on Energy and Commerce of the House of
2 Representatives and the Committee on Finance of
3 the Senate.

4 “(7) VOTING AND REPORTING REQUIRE-
5 MENTS.—With respect to each recommendation con-
6 tained in a report submitted under paragraph (1),
7 each member of the Commission shall vote on the
8 recommendation, and the Commission shall include,
9 by member, the results of that vote in the report
10 containing the recommendation.

11 “(8) EXAMINATION OF BUDGET CON-
12 SEQUENCES.—Before making any recommendations,
13 the Commission shall examine the budget con-
14 sequences of such recommendations, directly or
15 through consultation with appropriate expert enti-
16 ties.

17 “(c) APPLICATION OF PROVISIONS.—The following
18 provisions of section 1805 shall apply to the Commission
19 in the same manner as they apply to the Medicare Pay-
20 ment Advisory Commission:

21 “(1) Subsection (c) (relating to membership),
22 except that the membership of the Commission shall
23 also include representatives of children, pregnant
24 women, individuals with disabilities, seniors, low-in-

1 come families, and other groups of CHIP and Med-
2 icaid beneficiaries.

3 “(2) Subsection (d) (relating to staff and con-
4 sultants).

5 “(3) Subsection (e) (relating to powers).

6 “(d) AUTHORIZATION OF APPROPRIATIONS.—

7 “(1) REQUEST FOR APPROPRIATIONS.—The
8 Commission shall submit requests for appropriations
9 in the same manner as the Comptroller General sub-
10 mits requests for appropriations, but amounts ap-
11 propriated for the Commission shall be separate
12 from amounts appropriated for the Comptroller Gen-
13 eral.

14 “(2) AUTHORIZATION.—There are authorized to
15 be appropriated such sums as may be necessary to
16 carry out the provisions of this section.”.

17 **SEC. 142. MODEL OF INTERSTATE COORDINATED ENROLL-**
18 **MENT AND COVERAGE PROCESS.**

19 (a) IN GENERAL.—In order to assure continuity of
20 coverage of low-income children under the Medicaid pro-
21 gram and the State Children’s Health Insurance Program
22 (CHIP), not later than 18 months after the date of the
23 enactment of this Act, the Comptroller General of the
24 United States, in consultation with State Medicaid and
25 CHIP directors and organizations representing program

1 beneficiaries, shall develop a model process for the coordi-
2 nation of the enrollment, retention, and coverage under
3 such programs of children who, because of migration of
4 families, emergency evacuations, educational needs, or
5 otherwise, frequently change their State of residency or
6 otherwise are temporarily located outside of the State of
7 their residency.

8 (b) REPORT TO CONGRESS.—After development of
9 such model process, the Comptroller General shall submit
10 to Congress a report describing additional steps or author-
11 ity needed to make further improvements to coordinate the
12 enrollment, retention, and coverage under CHIP and Med-
13 icaid of children described in subsection (a).

14 **SEC. 143. MEDICAID CITIZENSHIP DOCUMENTATION RE-**
15 **QUIREMENTS.**

16 (a) STATE OPTION TO REQUIRE CHILDREN TO
17 PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF
18 PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES
19 OF ELIGIBILITY FOR MEDICAID; REQUIREMENT FOR AU-
20 DITING.—

21 (1) IN GENERAL.—Section 1902 of the Social
22 Security Act (42 U.S.C. 1396a) is amended—

23 (A) in subsection (a)(46)—

24 (i) by inserting “(A)” after “(46)”;

25 and

1 (B) by adding at the end the following new
2 subparagraphs:

3 “(B) at the option of the State, require that,
4 with respect to a child under 21 years of age (other
5 than an individual described in section 1903(x)(2))
6 who declares to be a citizen or national of the
7 United States for purposes of establishing initial eli-
8 gibility for medical assistance under this title (or, at
9 State option, for purposes of renewing or redeter-
10 mining such eligibility to the extent that such satis-
11 factory documentary evidence of citizenship or na-
12 tionality has not yet been presented), there is pre-
13 sented satisfactory documentary evidence of citizen-
14 ship or nationality of the individual (using criteria
15 determined by the State, which shall be no more re-
16 strictive than the documentation specified in section
17 1903(x)(3)); and

18 “(C) comply with the auditing requirements of
19 section 1903(x)(4);” and

20 (C) in subsection (b)(3), by inserting “or
21 any citizenship documentation requirement for
22 a child under 21 years of age that is more re-
23 strictive than what a State may provide under
24 section 1903(x)” before the period at the end.

1 (2) AUDITING REQUIREMENT.—Section 1903(x)
2 of such Act (as amended by section 405(c)(1)(A) of
3 division B of the Tax Relief and Health Care Act of
4 2006 (Public Law 109–432)) is amended by adding
5 at the end the following new paragraph:

6 “(4)(A) Regardless of whether a State has chosen to
7 take the option specified in section 1902(a)(46)(B), each
8 State shall audit a statistically-based sample of cases of
9 children under 21 years of age in order to demonstrate
10 to the satisfaction of the Secretary that the percentage
11 of Federal Medicaid funds being spent for non-emergency
12 benefits for aliens described in subsection (v)(1) who are
13 under 21 years of age does not exceed 3 percent of total
14 expenditures for medical assistance under the plan for
15 items and services for individuals under 21 years of age
16 for the period for which the sample is taken. In conducting
17 such audits, a State may rely on case reviews regularly
18 conducted pursuant to their Medicaid Quality Control or
19 Payment Error Rate Measurement (PERM) eligibility re-
20 views under subsection (u).

21 “(B) In conducting audits under subparagraph (A),
22 payments for non-emergency benefits shall be treated as
23 erroneous if the audit could not confirm the citizenship
24 of the individual based either on documentation in the case

1 file or on documentation obtained independently during
2 the audit.

3 “(C) If the erroneous error rate described in subpara-
4 graph (A)—

5 “(i) exceeds 3 percent, the State shall—

6 “(I) remit to the Secretary the Federal
7 share of improper expenditures in excess of the
8 3 percent level described in such subparagraph;

9 “(II) shall develop a corrective action plan;
10 and

11 “(III) shall conduct another audit the fol-
12 lowing fiscal year, after the corrective action
13 plan is implemented; or

14 “(ii) does not exceed 3 percent, the State is not
15 required to conduct another audit under subpara-
16 graph (A) until the third fiscal year succeeding the
17 fiscal year for which the audit was conducted.”;

18 (3) ELIMINATION OF DENIAL OF PAYMENTS
19 FOR CHILDREN.—Section 1903(i)(22) of such Act
20 (42 U.S.C. 1396b(i)(22)) is amended by inserting
21 “(other than a child under the age of 21)” after “for
22 an individual”.

23 (b) CLARIFICATION OF RULES FOR CHILDREN BORN
24 IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR

1 MEDICAID.—Section 1903(x)(2) of such Act (42 U.S.C.
2 1396b(x)(2)) is amended—

3 (1) in subparagraph (C), by striking “or” at
4 the end;

5 (2) by redesignating subparagraph (D) as sub-
6 paragraph (E); and

7 (3) by inserting after subparagraph (C) the fol-
8 lowing new subparagraph:

9 “(D) pursuant to the application of section
10 1902(e)(4) (and, in the case of an individual who is
11 eligible for medical assistance on such basis, the in-
12 dividual shall be deemed to have provided satisfac-
13 tory documentary evidence of citizenship or nation-
14 ality and shall not be required to provide further
15 documentary evidence on any date that occurs dur-
16 ing or after the period in which the individual is eli-
17 gible for medical assistance on such basis; or”.

18 (c) DOCUMENTATION FOR NATIVE AMERICANS .—
19 Section 1903(x)(3)(B) of such Act is amended—

20 (1) by redesignating clause (v) as clause (vi);
21 and

22 (2) by inserting after clause (iv) the following
23 new clause:

24 “(v) For an individual who is a member of,
25 or enrolled in or affiliated with, a federally-rec-

1 ognized Indian tribe, a document issued by such
2 tribe evidencing such membership, enrollment,
3 or affiliation with the tribe (such as a tribal en-
4 rollment card or certificate of degree of Indian
5 blood), and, only with respect to those federally-
6 recognized Indian tribes located within States
7 having an international border whose member-
8 ship includes individuals who are not citizens of
9 the United States, such other forms of docu-
10 mentation (including tribal documentation, if
11 appropriate) as the Secretary, after consulting
12 with such tribes, determines to be satisfactory
13 documentary evidence of citizenship or nation-
14 ality for purposes of satisfying the requirement
15 of this subparagraph.”.

16 (d) REASONABLE OPPORTUNITY.—Section 1903(x)
17 of such Act, as amended by subsection (a)(2), is further
18 amended by adding at the end the following new para-
19 graph:

20 “(5) In the case of an individual declaring to be a
21 citizen or national of the United States with respect to
22 whom a State requires the presentation of satisfactory
23 documentary evidence of citizenship or nationality under
24 section 1902(a)(46)(B), the individual shall be provided
25 at least the reasonable opportunity to present satisfactory

1 documentary evidence of citizenship or nationality under
2 this subsection as is provided under clauses (i) and (ii)
3 of section 1137(d)(4)(A) to an individual for the submittal
4 to the State of evidence indicating a satisfactory immigra-
5 tion status and shall not be denied medical assistance on
6 the basis of failure to provide such documentation until
7 the individual has had such an opportunity.”.

8 (e) EFFECTIVE DATE.—

9 (1) RETROACTIVE APPLICATION.—The amend-
10 ments made by this section shall take effect as if in-
11 cluded in the enactment of the Deficit Reduction Act
12 of 2005 (Public Law 109–171; 120 Stat. 4).

13 (2) RESTORATION OF ELIGIBILITY.—In the
14 case of an individual who, during the period that
15 began on July 1, 2006, and ends on the date of the
16 enactment of this Act, was determined to be ineli-
17 gible for medical assistance under a State Medicaid
18 program solely as a result of the application of sub-
19 sections (i)(22) and (x) of section 1903 of the Social
20 Security Act (as in effect during such period), but
21 who would have been determined eligible for such as-
22 sistance if such subsections, as amended by this sec-
23 tion, had applied to the individual, a State may
24 deem the individual to be eligible for such assistance
25 as of the date that the individual was determined to

1 be ineligible for such medical assistance on such
2 basis.

3 **SEC. 144. ACCESS TO DENTAL CARE FOR CHILDREN.**

4 (a) DENTAL EDUCATION FOR PARENTS OF
5 NEWBORNS.—The Secretary of Health and Human Serv-
6 ices shall develop and implement, through entities that
7 fund or provide perinatal care services to targeted low-
8 income children under a State child health plan under title
9 XXI of the Social Security Act, a program to deliver oral
10 health educational materials that inform new parents
11 about risks for, and prevention of, early childhood caries
12 and the need for a dental visit within their newborn's first
13 year of life.

14 (b) PROVISION OF DENTAL SERVICES THROUGH
15 FQHCs.—

16 (1) MEDICAID.—Section 1902(a) of the Social
17 Security Act (42 U.S.C. 1396a(a)) is amended—

18 (A) by striking “and” at the end of para-
19 graph (69);

20 (B) by striking the period at the end of
21 paragraph (70) and inserting “; and”; and

22 (C) by inserting after paragraph (70) the
23 following new paragraph:

24 “(71) provide that the State will not prevent a
25 Federally-qualified health center from entering into

1 contractual relationships with private practice dental
2 providers in the provision of Federally-qualified
3 health center services.”.

4 (2) CHIP.—Section 2107(e)(1) of such Act is
5 amended—

6 (A) by redesignating subparagraphs (B)
7 through (D) as subparagraphs (C) through (E);
8 and

9 (B) by inserting after subparagraph (A)
10 the following new subparagraph:

11 “(B) Section 1902(a)(71) (relating to lim-
12 iting FQHC contracting for provision of dental
13 services).”.

14 (3) EFFECTIVE DATE.—The amendments made
15 by this subsection shall take effect on January 1,
16 2008.

17 (c) REPORTING INFORMATION ON DENTAL
18 HEALTH.—

19 (1) MEDICAID.—Section 1902(a)(43)(D)(iii) of
20 such Act (42 U.S.C. 1396a(a)(43)(D)(iii)) is amend-
21 ed by inserting “and other information relating to
22 the provision of dental services to such children de-
23 scribed in section 2108(e)” after “receiving dental
24 services,”.

1 (2) CHIP.—Section 2108 of such Act (42
2 U.S.C. 1397hh) is amended by adding at the end
3 the following new subsection:

4 “(e) INFORMATION ON DENTAL CARE FOR CHILD-
5 DREN.—

6 “(1) IN GENERAL.—Each annual report under
7 subsection (a) shall include the following information
8 with respect to care and services described in section
9 1905(r)(3) provided to targeted low-income children
10 enrolled in the State child health plan under this
11 title at any time during the year involved:

12 “(A) The number of enrolled children by
13 age grouping used for reporting purposes under
14 section 1902(a)(43).

15 “(B) For children within each such age
16 grouping, information of the type contained in
17 questions 12(a)–(c) of CMS Form 416 (that
18 consists of the number of enrolled targeted low
19 income children who receive any, preventive, or
20 restorative dental care under the State plan).

21 “(C) For the age grouping that includes
22 children 8 years of age, the number of such
23 children who have received a protective sealant
24 on at least one permanent molar tooth.

1 “(2) INCLUSION OF INFORMATION ON ENROLL-
2 EES IN MANAGED CARE PLANS.—The information
3 under paragraph (1) shall include information on
4 children who are enrolled in managed care plans and
5 other private health plans and contracts with such
6 plans under this title shall provide for the reporting
7 of such information by such plans to the State.”.

8 (3) EFFECTIVE DATE.—The amendments made
9 by this subsection shall be effective for annual re-
10 ports submitted for years beginning after date of en-
11 actment.

12 (d) GAO STUDY AND REPORT.—

13 (1) STUDY.—The Comptroller General of the
14 United States shall provide for a study that exam-
15 ines—

16 (A) access to dental services by children in
17 underserved areas; and

18 (B) the feasibility and appropriateness of
19 using qualified mid-level dental health pro-
20 viders, in coordination with dentists, to improve
21 access for children to oral health services and
22 public health overall.

23 (2) REPORT.—Not later than 1 year after the
24 date of the enactment of this Act, the Comptroller

1 General shall submit to Congress a report on the
2 study conducted under paragraph (1).

3 **SEC. 145. PROHIBITING INITIATION OF NEW HEALTH OP-**
4 **PORTUNITY ACCOUNT DEMONSTRATION PRO-**
5 **GRAMS.**

6 After the date of the enactment of this Act, the Sec-
7 retary of Health and Human Services may not approve
8 any new demonstration programs under section 1938 of
9 the Social Security Act (42 U.S.C. 1396u-8).

10 **Subtitle F—Quality and Program**
11 **Integrity**

12 **SEC. 151. PEDIATRIC HEALTH QUALITY MEASUREMENT**
13 **PROGRAM.**

14 (a) QUALITY MEASUREMENT OF CHILDREN'S
15 HEALTH.—

16 (1) ESTABLISHMENT OF PROGRAM TO DEVELOP
17 QUALITY MEASURES FOR CHILDREN'S HEALTH.—

18 The Secretary of Health and Human Services (in
19 this section referred to as the “Secretary”) shall es-
20 tablish a child health care quality measurement pro-
21 gram (in this subsection referred to as the “chil-
22 dren’s health quality measurement program”) to de-
23 velop and implement—

24 (A) pediatric quality measures on chil-
25 dren’s health care that may be used by public

1 and private health care purchasers (and a sys-
2 tem for reporting such measures); and

3 (B) measures of overall program perform-
4 ance that may be used by public and private
5 health care purchasers.

6 The Secretary shall publish, not later than Sep-
7 tember 30, 2009, the recommended measures under
8 the program for application under the amendments
9 made by subsection (b) for years beginning with
10 2010.

11 (2) MEASURES.—

12 (A) SCOPE.—The measures developed
13 under the children's health quality measure-
14 ment program shall—

15 (i) provide comprehensive information
16 with respect to the provision and outcomes
17 of health care for young children, school
18 age children, and older children.

19 (ii) be designed to identify disparities
20 by pediatric characteristics (including, at a
21 minimum, those specified in subparagraph
22 (C)) in child health and the provision of
23 health care;

24 (iii) be designed to ensure that the
25 data required for such measures is col-

lected and reported in a standard format that permits comparison at a State, plan, and provider level, and between insured and uninsured children;

(iv) take into account existing measures of child health quality and be periodically updated;

(v) include measures of clinical health care quality which meet the requirements for pediatric quality measures in paragraph (1);

(vi) improve and augment existing measures of clinical health care quality for children's health care and develop new and emerging measures; and

(vii) increase the portfolio of evidence-based pediatric quality measures available to public and private purchasers, providers, and consumers.

(B) SPECIFIC MEASURES.—Such measures shall include measures relating to at least the following aspects of health care for children:

(i) The proportion of insured (and uninsured) children who receive age-appropriate preventive health and dental care

1 (including age appropriate immunizations)
2 at each stage of child health development.

3 (ii) The proportion of insured (and
4 uninsured) children who receive dental care
5 for restoration of teeth, relief of pain and
6 infection, and maintenance of dental
7 health.

8 (iii) The effectiveness of early health
9 care interventions for children whose as-
10 sessments indicate the presence or risk of
11 physical or mental conditions that could
12 adversely affect growth and development.

13 (iv) The effectiveness of treatment to
14 ameliorate the effects of diagnosed physical
15 and mental health conditions, including
16 chronic conditions.

17 (v) The proportion of children under
18 age 21 who are continuously insured for a
19 period of 12 months or longer.

20 (vi) The effectiveness of health care
21 for children with disabilities.

22 In carrying out clause (vi), the Secretary shall
23 develop quality measures and best practices re-
24 lating to cystic fibrosis.

(C) REPORTING METHODOLOGY FOR ANALYSIS BY PEDIATRIC CHARACTERISTICS.—The children's health quality measurement program shall describe with specificity such measures and the process by which such measures will be reported in a manner that permits analysis based on each of the following pediatric characteristics:

- (i) Age.
- (ii) Gender.
- (iii) Race.
- (iv) Ethnicity.
- (v) Primary language of the child's parents (or caretaker relative).
- (vi) Disability or chronic condition (including cystic fibrosis).
- (vii) Geographic location.
- (viii) Coverage status under public and private health insurance programs.

(D) PEDIATRIC QUALITY MEASURE.—In this subsection, the term "pediatric quality measure" means a measurement of clinical care that assesses one or more aspects of pediatric health care quality (in various settings) including the structure of the clinical care system, the

1 process and outcome of care, or patient experi-
2 ence in such care.

3 (3) CONSULTATION IN DEVELOPING QUALITY
4 MEASURES FOR CHILDREN'S HEALTH SERVICES.—In
5 developing and implementing the children's health
6 quality measurement program, the Secretary shall
7 consult with—

8 (A) States;

9 (B) pediatric hospitals, pediatricians, and
10 other primary and specialized pediatric health
11 care professionals (including members of the al-
12 lied health professions) who specialize in the
13 care and treatment of children, particularly
14 children with special physical, mental, and de-
15 velopmental health care needs;

16 (C) dental professionals;

17 (D) health care providers that furnish pri-
18 mary health care to children and families who
19 live in urban and rural medically underserved
20 communities or who are members of distinct
21 population sub-groups at heightened risk for
22 poor health outcomes;

23 (E) national organizations representing
24 children, including children with disabilities and
25 children with chronic conditions;

1 (F) national organizations and individuals
2 with expertise in pediatric health quality per-
3 formance measurement; and

4 (G) voluntary consensus standards setting
5 organizations and other organizations involved
6 in the advancement of evidence based measures
7 of health care.

8 (4) USE OF GRANTS AND CONTRACTS.—In car-
9 rying out the children's health quality measurement
10 program, the Secretary may award grants and con-
11 tracts to develop, test, validate, update, and dissemi-
12 nate quality measures under the program.

13 (5) TECHNICAL ASSISTANCE.—The Secretary
14 shall provide technical assistance to States to estab-
15 lish for the reporting of quality measures under ti-
16 tles XIX and XXI of the Social Security Act in ac-
17 cordance with the children's health quality measure-
18 ment program.

19 (b) DISSEMINATION OF INFORMATION ON THE QUAL-
20 ITY OF PROGRAM PERFORMANCE.—Not later than Janu-
21 ary 1, 2009, and annually thereafter, the Secretary shall
22 collect, analyze, and make publicly available on a public
23 website of the Department of Health and Human Services
24 in an online format—

1 (1) a complete list of all measures in use by
2 States as of such date and used to measure the
3 quality of medical and dental health services fur-
4 nished to children enrolled under title XIX of XXI
5 of the Social Security Act by participating providers,
6 managed care entities, and plan issuers; and

7 (2) information on health care quality for chil-
8 dren contained in external quality review reports re-
9 quired under section 1932(c)(2) of such Act (42
10 U.S.C. 1396u-2) or produced by States that admin-
11 ister separate plans under title XXI of such Act.

12 (c) REPORTS TO CONGRESS ON PROGRAM PERFORM-
13 ANCE.—Not later than January 1, 2010, and every 2
14 years thereafter, the Secretary shall report to Congress
15 on—

16 (1) the quality of health care for children en-
17 rolled under title XIX and XXI of the Social Secu-
18 rity Act under the children's health quality measure-
19 ment program; and

20 (2) patterns of health care utilization with re-
21 spect to the measures specified in subsection
22 (a)(2)(B) among children by the pediatric character-
23 istics listed in subsection (a)(2)(C).

1 **SEC. 152. APPLICATION OF CERTAIN MANAGED CARE**
2 **QUALITY SAFEGUARDS TO CHIP.**

3 (a) IN GENERAL.—Section 2103(f) of Social Security
4 Act (42 U.S.C. 1397bb(f)) is amended by adding at the
5 end the following new paragraph:

6 “(3) COMPLIANCE WITH MANAGED CARE RE-
7 QUIREMENTS.—The State child health plan shall
8 provide for the application of subsections (a)(4),
9 (a)(5), (b), (c), (d), and (e) of section 1932 (relating
10 to requirements for managed care) to coverage,
11 State agencies, enrollment brokers, managed care
12 entities, and managed care organizations under this
13 title in the same manner as such subsections apply
14 to coverage and such entities and organizations
15 under title XIX.”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 subsection (a) shall apply to contract years for health
18 plans beginning on or after July 1, 2008.

19 **SEC. 153. UPDATED FEDERAL EVALUATION OF CHIP.**

20 Section 2108(c) of the Social Security Act (42 U.S.C.
21 1397hh(c)) is amended by striking paragraph (5) and in-
22 serting the following:

23 “(5) SUBSEQUENT EVALUATION USING UP-
24 DATED INFORMATION.—

25 “(A) IN GENERAL.—The Secretary, di-
26 rectly or through contracts or interagency

1 agreements, shall conduct an independent sub-
2 sequent evaluation of 10 States with approved
3 child health plans.

4 “(B) SELECTION OF STATES AND MAT-
5 TERS INCLUDED.—Paragraphs (2) and (3) shall
6 apply to such subsequent evaluation in the
7 same manner as such provisions apply to the
8 evaluation conducted under paragraph (1).

9 “(C) SUBMISSION TO CONGRESS.—Not
10 later than December 31, 2010, the Secretary
11 shall submit to Congress the results of the eval-
12 uation conducted under this paragraph.

13 “(D) FUNDING.—Out of any money in the
14 Treasury of the United States not otherwise ap-
15 propriated, there are appropriated \$10,000,000
16 for fiscal year 2009 for the purpose of con-
17 ducting the evaluation authorized under this
18 paragraph. Amounts appropriated under this
19 subparagraph shall remain available for expend-
20 iture through fiscal year 2011.” .

21 **SEC. 154. ACCESS TO RECORDS FOR IG AND GAO AUDITS**
22 **AND EVALUATIONS.**

23 Section 2108(d) of the Social Security Act (42 U.S.C.
24 1397hh(d)) is amended to read as follows:

1 “(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS
2 AND EVALUATIONS.—For the purpose of evaluating and
3 auditing the program established under this title, the Sec-
4 retary, the Office of Inspector General, and the Comp-
5 troller General shall have access to any books, accounts,
6 records, correspondence, and other documents that are re-
7 lated to the expenditure of Federal funds under this title
8 and that are in the possession, custody, or control of
9 States receiving Federal funds under this title or political
10 subdivisions thereof, or any grantee or contractor of such
11 States or political subdivisions.”.

12 **SEC. 155. REFERENCES TO TITLE XXI.**

13 Section 704 of the Medicare, Medicaid, and SCHIP
14 Balanced Budget Refinement Act of 1999 (Appendix F,
15 113 Stat. 1501A–321), as enacted into law by section
16 1000(a)(6) of Public Law 106–113) is repealed.

17 **SEC. 156. RELIANCE ON LAW; EXCEPTION FOR STATE LEG-**
18 **ISLATION.**

19 (a) RELIANCE ON LAW.— With respect to amend-
20 ments made by this title or title VIII that become effective
21 as of a date—

22 (1) such amendments are effective as of such
23 date whether or not regulations implementing such
24 amendments have been issued; and

1 (2) Federal financial participation for medical
2 assistance or child health assistance furnished under
3 title XIX or XXI, respectively, of the Social Security
4 Act on or after such date by a State in good faith
5 reliance on such amendments before the date of pro-
6 mulgation of final regulations, if any, to carry out
7 such amendments (or before the date of guidance, if
8 any, regarding the implementation of such amend-
9 ments) shall not be denied on the basis of the
10 State's failure to comply with such regulations or
11 guidance.

12 (b) EXCEPTION FOR STATE LEGISLATION.—In the
13 case of a State plan under title XIX or State child health
14 plan under XXI of the Social Security Act, which the Sec-
15 retary of Health and Human Services determines requires
16 State legislation in order for respective plan to meet one
17 or more additional requirements imposed by amendments
18 made by this title or title VIII, the respective State plan
19 shall not be regarded as failing to comply with the require-
20 ments of such title solely on the basis of its failure to meet
21 such an additional requirement before the first day of the
22 first calendar quarter beginning after the close of the first
23 regular session of the State legislature that begins after
24 the date of enactment of this Act. For purposes of the
25 previous sentence, in the case of a State that has a 2-

1 year legislative session, each year of the session shall be
2 considered to be a separate regular session of the State
3 legislature.

4 **TITLE II—MEDICARE**
5 **BENEFICIARY IMPROVEMENTS**
6 **Subtitle A—Improvements in**
7 **Benefits**

8 **SEC. 201. COVERAGE AND WAIVER OF COST-SHARING FOR**
9 **PREVENTIVE SERVICES.**

10 (a) PREVENTIVE SERVICES DEFINED; COVERAGE OF
11 ADDITIONAL PREVENTIVE SERVICES.—Section 1861 of
12 the Social Security Act (42 U.S.C. 1395x) is amended—

13 (1) in subsection (s)(2)—

14 (A) in subparagraph (Z), by striking
15 “and” after the semicolon at the end;

16 (B) in subparagraph (AA), by adding
17 “and” after the semicolon at the end; and

18 (C) by adding at the end the following new
19 subparagraph:

20 “(BB) additional pre-
21 ventive services (described in
22 subsection (ccc)(1)(M));”;
23 and

24 (2) by adding at the end the following new sub-
25 section:

1 “Preventive Services

2 “(ccc)(1) The term ‘preventive services’ means the
3 following:

4 “(A) Prostate cancer screening tests (as
5 defined in subsection (oo)).

6 “(B) Colorectal cancer screening tests (as
7 defined in subsection (pp)).

8 “(C) Diabetes outpatient self-management
9 training services (as defined in subsection (qq)).

10 “(D) Screening for glaucoma for certain
11 individuals (as described in subsection
12 (s)(2)(U)).

13 “(E) Medical nutrition therapy services for
14 certain individuals (as described in subsection
15 (s)(2)(V)).

16 “(F) An initial preventive physical exam-
17 ination (as defined in subsection (ww)).

18 “(G) Cardiovascular screening blood tests
19 (as defined in subsection (xx)(1)).

20 “(H) Diabetes screening tests (as defined
21 in subsection described in subsection (s)(2)(Y)).

22 “(I) Ultrasound screening for abdominal
23 aortic aneurysm for certain individuals (as de-
24 scribed in described in subsection (s)(2)(AA)).

1 “(J) Pneumococcal and influenza vaccine
2 and their administration (as described in sub-
3 section (s)(10)(A)).

4 “(K) Hepatitis B vaccine and its adminis-
5 tration for certain individuals (as described in
6 subsection (s)(10)(B)).

7 “(L) Screening mammography (as defined
8 in subsection (jj)).

9 “(M) Screening pap smear and screening
10 pelvic exam (as described in subsection (s)(14)).

11 “(N) Bone mass measurement (as defined
12 in subsection (rr)).

13 “(O) Additional preventive services (as de-
14 termined under paragraph (2)).

15 “(2)(A) The term ‘additional preventive serv-
16 ices’ means items and services, including mental
17 health services, not described in subparagraphs (A)
18 through (N) of paragraph (1) that the Secretary de-
19 termines to be reasonable and necessary for the pre-
20 vention or early detection of an illness or disability.

21 “(B) In making determinations under subpara-
22 graph (1), the Secretary shall—

23 “(C) take into account evidence-based rec-
24 ommendations by the United States Preventive

1 Services Task Force and other appropriate or-
2 ganizations; and

3 “(D) use the process for making national
4 coverage determinations (as defined in section
5 1869(f)(1)(B)) under this title.”.

6 (b) PAYMENT AND ELIMINATION OF COST-SHAR-
7 ING.—

8 (1) IN GENERAL.—Section 1833(a)(1) of the
9 Social Security Act (42 U.S.C. 1395l(a)(1)) is
10 amended—

11 (A) in clause (T), by striking “80 percent”
12 and inserting “100 percent”; and

13 (B) by striking “and” before “(V)”; and

14 (C) by inserting before the semicolon at
15 the end the following: “, and (W) with respect
16 to additional preventive services (as defined in
17 section 1861(ccc)(2)) and other preventive serv-
18 ices for which a payment rate is not otherwise
19 established under this section, the amount paid
20 shall be 100 percent of the lesser of the actual
21 charge for the services or the amount deter-
22 mined under a fee schedule established by the
23 Secretary for purposes of this clause”.

24 (2) ELIMINATION OF COINSURANCE IN OUT-
25 PATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking “screening mammography (as defined in section 1861(jj)) and diagnostic mammography” and inserting “diagnostic mammography and preventive services (as defined in section 1861(ccc)(1))”.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking

“and” after the semicolon at the end;

(ii) in subparagraph (G)(ii), by adding

“and” at the end; and

(iii) by adding at the end the following new subparagraph:

“(H) with respect to additional preventive services (as defined in section 1861(ccc)(2)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);”.

(3) WAIVER OF APPLICATION OF DEDUCTIBLE FOR ALL PREVENTIVE SERVICES.—The first sen-

1 tence of section 1833(b) of the Social Security Act
2 (42 U.S.C. 1395l(b)) is amended —

3 (A) in clause (1), by striking “items and
4 services described in section 1861(s)(10)(A)”
5 and inserting “preventive services (as defined in
6 section 1861(ccc)(1))”;

7 (B) by inserting “and” before “(4)”; and

8 (C) by striking clauses (5) through (8).

9 (c) **INCLUSION AS PART OF INITIAL PREVENTIVE**
10 **PHYSICAL EXAMINATION.**—Section 1861(ww)(2) of the
11 Social Security Act (42 U.S.C. 1395x(ww)(2)) is amended
12 by adding at the end the following new subparagraph:

13 “(M) Additional preventive services (as de-
14 fined in subsection (ccc)(2)).”.

15 (d) **EFFECTIVE DATE.**—The amendments made by
16 this section shall apply to services furnished on or after
17 January 1, 2008.

18 **SEC. 202. WAIVER OF DEDUCTIBLE FOR COLORECTAL CAN-**
19 **CER SCREENING TESTS REGARDLESS OF**
20 **CODING, SUBSEQUENT DIAGNOSIS, OR ANCIL-**
21 **LARY TISSUE REMOVAL.**

22 (a) **IN GENERAL.**—Section 1833(b)(8) of the Social
23 Security Act (42 U.S.C. 1395l(b)(8)) is amended by in-
24 serting “, regardless of the code applied, of the establish-
25 ment of a diagnosis as a result of the test, or of the re-

1 moval of tissue or other matter or other procedure that
2 is performed in connection with and as a result of the
3 screening test” after “1861(pp)(1))”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall apply to items and services furnished
6 on or after January 1, 2008.

7 **SEC. 203. PARITY FOR MENTAL HEALTH COINSURANCE.**

8 Section 1833(c) of the Social Security Act (42 U.S.C.
9 1395l(c)) is amended—

10 (1) in the first sentence, by striking “62–1/2
11 percent” and inserting “the incurred expense per-
12 centage (as specified in the last sentence)”; and

13 (2) by adding at the end the following: “For
14 purposes of this subsection, the ‘incurred expense
15 percentage’ is equal to 62–1/2 percent increased, for
16 each year beginning with 2008, by 6–1/4 percentage
17 points, but not to exceed 100 percent.”.

1 Subtitle B—Improving, Clarifying,
2 and Simplifying Financial As-
3 sistance for Low Income Medi-
4 care Beneficiaries

5 SEC. 211. IMPROVING ASSETS TESTS FOR MEDICARE SAV-
6 INGS PROGRAM AND LOW-INCOME SUBSIDY
7 PROGRAM.

8 (a) APPLICATION OF HIGHEST LEVEL PERMITTED
9 UNDER LIS.—

10 (1) TO FULL-PREMIUM SUBSIDY ELIGIBLE INDIV-
11 IDUALS.—Section 1860D–14(a) of the Social Secu-
12 rity Act (42 U.S.C. 1395w-114(a)) is amended—

13 (A) in paragraph (1), in the matter before
14 subparagraph (A), by inserting “(or, beginning
15 with 2009, paragraph (3)(E))” after “para-
16 graph (3)(D)”; and

17 (B) in paragraph (3)(A)(iii), by striking
18 “(D) or”.

19 (2) ANNUAL INCREASE IN LIS RESOURCE
20 TEST.—Section 1860D–14(a)(3)(E)(i) of such Act
21 (42 U.S.C. 1395w-114(a)(3)(E)(i)) is amended—

22 (A) by striking “and” at the end of sub-
23 clause (I);

24 (B) in subclause (II), by inserting “(before
25 2009)” after “subsequent year”;

1 (C) by striking the period at the end of
2 subclause (II) and inserting a semicolon; and

3 (D) by inserting after subclause (II) the
4 following new subclauses:

5 “(III) for 2009, \$17,000 (or
6 \$34,000 in the case of the combined
7 value of the individual’s assets or re-
8 sources and the assets or resources of
9 the individual’s spouse); and

10 “(IV) for a subsequent year, the
11 dollar amounts specified in this sub-
12 clause (or subclause (III)) for the pre-
13 vious year increased by \$1,000 (or
14 \$2,000 in the case of the combined
15 value referred to in subclause (III)).”.

16 (3) APPLICATION OF LIS TEST UNDER MEDI-
17 CARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of
18 such Act (42 U.S.C. 1396d(p)(1)(C)) is amended by
19 inserting before the period at the end the following:
20 “or, effective beginning with January 1, 2009, whose
21 resources (as so determined) do not exceed the max-
22 imum resource level applied for the year under sec-
23 tion 1860D–14(a)(3)(E) applicable to an individual
24 or to the individual and the individual’s spouse (as
25 the case may be)”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to eligibility determinations for
3 income-related subsidies and medicare cost-sharing fur-
4 nished for periods beginning on or after January 1, 2009.

5 **SEC. 212. MAKING QI PROGRAM PERMANENT AND EXPAND-**
6 **ING ELIGIBILITY.**

7 (a) MAKING PROGRAM PERMANENT.—

8 (1) IN GENERAL.—Section 1902(a)(10)(E)(iv)
9 of the Social Security Act (42 U.S.C.
10 1396b(a)(10)(E)(iv)) is amended—

11 (A) by striking “sections 1933 and” and
12 by inserting “section”; and

13 (B) by striking “(but only with” and all
14 that follows through “September 2007”).

15 (2) ELIMINATION OF FUNDING LIMITATION.—

16 (A) IN GENERAL.—Section 1933 of such
17 Act (42 U.S.C. 1396u-3) is amended—

18 (i) in subsection (a), by striking “who
19 are selected to receive such assistance
20 under subsection (b)”

21 (ii) by striking subsections (b), (c),
22 (e), and (g);

23 (iii) in subsection (d), by striking
24 “furnished in a State” and all that follows
25 and inserting “the Federal medical assist-

1 ance percentage shall be equal to 100 per-
2 cent.”; and
3 (iv) by redesignating subsections (d)
4 and (f) as subsections (b) and (c), respec-
5 tively.

6 (B) CONFORMING AMENDMENT.—Section
7 1905(b) of such Act (42 U.S.C. 1396d(b)) is
8 amended by striking “1933(d)” and inserting
9 “1933(b)”.

10 (C) EFFECTIVE DATE.—The amendments
11 made by subparagraph (A) shall take effect on
12 October 1, 2007.

13 (b) INCREASE IN ELIGIBILITY TO 150 PERCENT OF
14 THE FEDERAL POVERTY LEVEL.—Section
15 1902(a)(10)(E)(iv) of such Act is further amended by in-
16 serting “(or, effective January 1, 2008, 150 percent)”
17 after “135 percent”.

18 **SEC. 213. ELIMINATING BARRIERS TO ENROLLMENT.**

19 (a) ADMINISTRATIVE VERIFICATION OF INCOME AND
20 RESOURCES UNDER THE LOW-INCOME SUBSIDY PRO-
21 GRAM.—Section 1860D–14(a)(3) of the Social Security
22 Act (42 U.S.C. 1395w–114(a)(3)) is amended by adding
23 at the end the following new subparagraph:

24 “(G) SELF-CERTIFICATION OF INCOME
25 AND RESOURCES.—For purposes of applying

1 this section, an individual shall be permitted to
2 qualify on the basis of self-certification of in-
3 come and resources without the need to provide
4 additional documentation.”.

5 (b) AUTOMATIC REENROLLMENT WITHOUT NEED TO
6 REAPPLY UNDER LOW-INCOME SUBSIDY PROGRAM.—

7 Section 1860D–14(a)(3) of such Act (42 U.S.C. 1395w-
8 114(a)(3)), as amended by subsection (a), is further
9 amended by adding at the end the following new subpara-
10 graph:

11 “(H) AUTOMATIC REENROLLMENT.—For
12 purposes of applying this section, in the case of
13 an individual who has been determined to be a
14 subsidy eligible individual (and within a par-
15 ticular class of such individuals, such as a full-
16 subsidy eligible individual or a partial subsidy
17 eligible individual), the individual shall be
18 deemed to continue to be so determined without
19 the need for any annual or periodic application
20 unless and until the individual notifies a Fed-
21 eral or State official responsible for such deter-
22 minations that the individual’s eligibility condi-
23 tions have changed so that the individual is no
24 longer a subsidy eligible individual (or is no
25 longer within such class of such individuals).”.

1 (c) ENCOURAGING APPLICATION OF PROCEDURES
2 UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)
3 of such Act (42 U.S.C. 1396d(p)) is amended by adding
4 at the end the following new paragraph:

5 “(7) The Secretary shall take all reasonable
6 steps to encourage States to provide for administra-
7 tive verification of income and automatic reenroll-
8 ment (as provided under clauses (iii) and (iv) of sec-
9 tion 1860D–14(a)(3)(C) in the case of the low-in-
10 come subsidy program).”.

11 (d) SSA ASSISTANCE WITH MEDICARE SAVINGS
12 PROGRAM AND LOW-INCOME SUBSIDY PROGRAM APPLI-
13 CATIONS.—Section 1144 of such Act (42 U.S.C. 1320b-
14 14) is amended by adding at the end the following new
15 subsection:

16 “(c) ASSISTANCE WITH MEDICARE SAVINGS PRO-
17 GRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICA-
18 TIONS.—

19 “(1) DISTRIBUTION OF APPLICATIONS TO AP-
20 PPLICANTS FOR MEDICARE.—In the case of each indi-
21 vidual applying for hospital insurance benefits under
22 section 226 or 226A, the Commissioner shall provide
23 the following:

24 “(A) Information describing the low-in-
25 come subsidy program under section 1860D–14

1 and the medicare savings program under title
2 XIX.

3 “(B) An application for enrollment under
4 such low-income subsidy program as well as an
5 application form (developed under section
6 1905(p)(5)) for medical assistance for medicare
7 cost-sharing under title XIX.

8 “(C) Information on how the individual
9 may obtain assistance in completing such appli-
10 cations, including information on how the indi-
11 vidual may contact the State health insurance
12 assistance program (SHIP) for the State in
13 which the individual is located.

14 The Commissioner shall make such application
15 forms available at local offices of the Social Security
16 Administration.

17 “(2) TRAINING PERSONNEL IN ASSISTING IN
18 COMPLETING APPLICATIONS.—The Commissioner
19 shall provide training to those employees of the So-
20 cial Security Administration who are involved in re-
21 ceiving applications for benefits described in para-
22 graph (1) in assisting applicants in completing a
23 medicare savings program application described in
24 paragraph (1). Such employees who are so trained
25 shall provide such assistance upon request.

1 “(3) TRANSMITTAL OF COMPLETED APPLICA-
2 TION.—If such an employee assists in completing
3 such an application, the employee, with the consent
4 of the applicant, shall transmit the completed appli-
5 cation to the appropriate State medicaid agency for
6 processing.

7 “(4) COORDINATION WITH OUTREACH.—The
8 Commissioner shall coordinate outreach activities
9 under this subsection with outreach activities con-
10 ducted by States in connection with the low-income
11 subsidy program and the medicare savings pro-
12 gram.”.

13 (e) MEDICAID AGENCY CONSIDERATION OF APPLICA-
14 TIONS.—Section 1935(a) of such Act (42 U.S.C. 1396u-
15 5(a)) is amended by adding at the end the following new
16 paragraph:

17 “(4) CONSIDERATION OF MSP APPLICATIONS.—
18 The State shall accept medicare savings program ap-
19 plications transmitted under section 1144(c)(3) and
20 act on such applications in the same manner and
21 deadlines as if they had been submitted directly by
22 the applicant.”.

23 (f) TRANSLATION OF MODEL FORM.—Section
24 1905(p)(5)(A) of the Social Security Act (42 U.S.C.
25 1396d(p)(5)(A)) is amended by adding at the end the fol-

1 lowing: "The Secretary shall provide for the translation
2 of such application form into at least the 10 languages
3 (other than English) that are most often used by individ-
4 uals applying for hospital insurance benefits under section
5 226 or 226A and shall make the translated forms available
6 to the States and to the Commissioner of Social Secu-
7 rity."

8 (g) DISCLOSURE OF TAX RETURN INFORMATION FOR
9 PURPOSES OF PROVIDING LOW-INCOME SUBSIDIES
10 UNDER MEDICARE.—

11 (1) IN GENERAL.—Subsection (l) of section
12 6103 of the Internal Revenue Code of 1986 is
13 amended by adding at the end the following new
14 paragraph:

15 "(21) DISCLOSURE OF RETURN INFORMATION
16 FOR PURPOSES OF PROVIDING LOW-INCOME SUB-
17 SIDIES UNDER MEDICARE.—

18 "(A) RETURN INFORMATION FROM INTER-
19 NAL REVENUE SERVICE TO SOCIAL SECURITY
20 ADMINISTRATION.—The Secretary, upon writ-
21 ten request from the Commissioner of Social
22 Security, shall disclose to the officers and em-
23 ployees of the Social Security Administration
24 with respect to any individual identified by the
25 Commissioner as potentially eligible (based on

1 information other than return information) for
2 low-income subsidies under section 1860D-14
3 of the Social Security Act—

4 “(i) whether the adjusted gross in-
5 come for the applicable year is less than
6 135 percent of the poverty line (as speci-
7 fied by the Commissioner in such request),

8 “(ii) whether such adjusted gross in-
9 come is between 135 percent and 150 per-
10 cent of the poverty line (as so specified),

11 “(iii) whether any designated distribu-
12 tions (as defined in section 3405(e)(1))
13 were reported with respect to such indi-
14 vidual under section 6047(d) for the appli-
15 cable year, and the amount (if any) of the
16 distributions so reported,

17 “(iv) whether the return was a joint
18 return for the applicable year, and

19 “(v) the applicable year.

20 “(B) APPLICABLE YEAR.—

21 “(i) IN GENERAL.—For the purposes
22 of this paragraph, the term ‘applicable
23 year’ means the most recent taxable year
24 for which information is available in the
25 Internal Revenue Service’s taxpayer data

1 information systems, or, if there is no re-
2 turn filed for the individual for such year,
3 the prior taxable year.

4 “(ii) NO RETURN.—If no return is
5 filed for such individual for both taxable
6 years referred to in clause (i), the Sec-
7 retary shall disclose the fact that there is
8 no return filed for such individual for the
9 applicable year in lieu of the information
10 described in subparagraph (A).

11 “(C) RESTRICTION ON USE OF DISCLOSED
12 INFORMATION.—Return information disclosed
13 under this paragraph may be used only for the
14 purpose of improving the efforts of the Social
15 Security Administration to contact and assist
16 eligible individuals for, and administering, low-
17 income subsidies under section 1860D–14 of
18 the Social Security Act.

19 “(D) TERMINATION.—No disclosure shall
20 be made under this paragraph after the 2-year
21 period beginning on the date of the enactment
22 of this paragraph.”.

23 (2) PROCEDURES AND RECORDKEEPING RE-
24 LATED TO DISCLOSURES.—Paragraph (4) of section
25 6103(p) of such Code is amended by striking “or

1 (17)” each place it appears and inserting “(17), or
2 (21)”.

3 (3) REPORT.—Not later than 18 months after
4 the date of the enactment of this Act, the Secretary
5 of the Treasury, after consultation with the Commis-
6 sioner of Social Security, shall submit a written re-
7 port to Congress regarding the use of disclosures
8 made under section 6103(l)(21) of the Internal Rev-
9 enue Code of 1986, as added by this subsection, in
10 identifying individuals eligible for the low-income
11 subsidies under section 1860D–14 of the Social Se-
12 curity Act.

13 (4) EFFECTIVE DATE.—The amendment made
14 by this subsection shall apply to disclosures made
15 after the date of the enactment of this Act.

16 (h) EFFECTIVE DATE.—Except as otherwise pro-
17 vided, the amendments made by this section shall take ef-
18 fect on January 1, 2009.

19 **SEC. 214. ELIMINATING APPLICATION OF ESTATE RECOV-**
20 **ERY.**

21 (a) IN GENERAL.—Section 1917(b)(1)(B)(ii) of the
22 Social Security Act (42 U.S.C. 1396p(b)(1)(B)(ii)) is
23 amended by inserting “(but not including medical assist-
24 ance for medicare cost-sharing or for benefits described
25 in section 1902(a)(10)(E))” before the period at the end.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect as of January 1, 2008.

3 **SEC. 215. ELIMINATION OF PART D COST-SHARING FOR**
4 **CERTAIN NON-INSTITUTIONALIZED FULL-**
5 **BENEFIT DUAL ELIGIBLE INDIVIDUALS.**

6 (a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of
7 the Social Security Act (42 U.S.C. 1395w–
8 114(a)(1)(D)(i)) is amended—

9 (1) in the heading, by striking “INSTITU-
10 TIONALIZED INDIVIDUALS.—In” and inserting
11 “ELIMINATION OF COST-SHARING FOR CERTAIN
12 FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

13 “(I) INSTITUTIONALIZED INDI-
14 VIDUALS.—In”; and

15 (2) by adding at the end the following new sub-
16 clause:

17 “(II) CERTAIN OTHER INDIVID-
18 UALS.—In the case of an individual
19 who is a full-benefit dual eligible indi-
20 vidual and with respect to whom there
21 has been a determination that but for
22 the provision of home and community
23 based care (whether under section
24 1915 or under a waiver under section
25 1115) the individual would require the

1 level of care provided in a hospital or
2 a nursing facility or intermediate care
3 facility for the mentally retarded the
4 cost of which could be reimbursed
5 under the State plan under title XIX,
6 the elimination of any beneficiary co-
7 insurance described in section 1860D-
8 2(b)(2) (for all amounts through the
9 total amount of expenditures at which
10 benefits are available under section
11 1860D-2(b)(4)).”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to drugs dispensed on or after
14 January 1, 2009.

15 **SEC. 216. EXEMPTIONS FROM INCOME AND RESOURCES**
16 **FOR DETERMINATION OF ELIGIBILITY FOR**
17 **LOW-INCOME SUBSIDY.**

18 (a) IN GENERAL.—Section 1860D-14(a)(3) of the
19 Social Security Act (42 U.S.C. 1395w-114(a)(3)), as
20 amended by subsections (a) and (b) of section 213, is fur-
21 ther amended—

22 (1) in subparagraph (C)(i), by inserting “and
23 except that support and maintenance furnished in
24 kind shall not be counted as income” after “section
25 1902(r)(2)”;

1 (2) in subparagraph (D), in the matter before
2 clause (i), by inserting “subject to the additional ex-
3 clusions provided under subparagraph (G)” before
4 “);

5 (3) in subparagraph (E)(i), in the matter before
6 subelause (I), by inserting “subject to the additional
7 exclusions provided under subparagraph (G)” before
8 “); and

9 (4) by adding at the end the following new sub-
10 paragraph:

11 “(I) ADDITIONAL EXCLUSIONS.—In deter-
12 mining the resources of an individual (and the
13 eligible spouse of the individual, if any) under
14 section 1613 for purposes of subparagraphs (D)
15 and (E) the following additional exclusions shall
16 apply:

17 “(i) LIFE INSURANCE POLICY.—No
18 part of the value of any life insurance pol-
19 icy shall be taken into account.

20 “(ii) PENSION OR RETIREMENT
21 PLAN.—No balance in any pension or re-
22 tirement plan shall be taken into ac-
23 count.”.

24 (b) EFFECTIVE DATE.—The amendments made by
25 this section shall take effect on January 1, 2009, and shall

1 apply to determinations of eligibility for months beginning
2 with January 2009.

3 **SEC. 217. COST-SHARING PROTECTIONS FOR LOW-INCOME**
4 **SUBSIDY-ELIGIBLE INDIVIDUALS.**

5 (a) IN GENERAL.—Section 1860D–14(a) of the So-
6 cial Security Act (42 U.S.C. 1395w–114(a)) is amended—

7 (1) in paragraph (1)(D), by adding at the end
8 the following new clause:

9 “(iv) OVERALL LIMITATION ON COST-
10 SHARING.—In the case of all such individ-
11 uals, a limitation on aggregate cost-sharing
12 under this part for a year not to exceed
13 2.5 percent of income.”; and

14 (2) in paragraph (2), by adding at the end the
15 following new subparagraph:

16 “(F) OVERALL LIMITATION ON COST-SHAR-
17 ING.—A limitation on aggregate cost-sharing
18 under this part for a year not to exceed 2.5 per-
19 cent of income.”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 subsection (a) shall apply as of January 1, 2009.

22 **SEC. 218. INTELLIGENT ASSIGNMENT IN ENROLLMENT.**

23 (a) IN GENERAL.—Section 1860D–1(b)(1) of the So-
24 cial Security Act (42 U.S.C. 1395w–101(b)(1)) is amend-
25 ed—

1 (1) in the second sentence of subparagraph (C),
2 by inserting “, subject to subparagraph (D),” before
3 “on a random basis”; and

4 (2) by adding at the end the following new sub-
5 paragraph:”.

6 “(D) INTELLIGENT ASSIGNMENT.—In the
7 case of any auto-enrollment under subpara-
8 graph (C), no part D eligible individual de-
9 scribed in such subparagraph shall be enrolled
10 in a prescription drug plan which does not meet
11 the following requirements:

12 “(i) FORMULARY.—The plan has a
13 formulary that covers at least—

14 “(I) 95 percent of the 100 most
15 commonly prescribed non-duplicative
16 generic covered part D drugs for the
17 population of individuals entitled to
18 benefits under part A or enrolled
19 under part B; and

20 “(II) 95 percent of the 100 most
21 commonly prescribed non-duplicative
22 brand name covered part D drugs for
23 such population.

24 “(ii) PHARMACY NETWORK.—The
25 plan has a network of pharmacies that

substantially exceeds the minimum requirements for prescription drug plans in the State and that provides access in areas where lower income individuals reside.

“(iii) QUALITY.—

“(I) IN GENERAL.—Subject to subclause (I), the plan has an above average score on quality ratings of the Secretary of prescription drug plans under this part.

“(II) EXCEPTION.—Subclause (I) shall not apply to a plan that is a new plan (as defined by the Secretary), with respect to the plan year involved.

“(iv) LOW COST.—The total cost under this title of providing prescription drug coverage under the plan consistent with the previous clauses of this subparagraph is among the lowest 25th percentile of prescription drug plans under this part in the State.

In the case that no plan meets the requirements under clauses (i) through (iv), the Secretary shall implement this subparagraph to the greatest extent possible with the goal of protecting

1 beneficiary access to drugs without increasing
2 the cost relative to the enrollment process under
3 subparagraph (C) as in existence before the
4 date of the enactment of this subparagraph.”.

5 (b) EFFECTIVE DATE.—The amendment made by
6 subsection (a) shall take effect for enrollments effected on
7 or after November 15, 2009.

8 **Subtitle C—Part D Beneficiary**
9 **Improvements**

10 **SEC. 221. INCLUDING COSTS INCURRED BY AIDS DRUG AS-**
11 **SISTANCE PROGRAMS AND INDIAN HEALTH**
12 **SERVICE IN PROVIDING PRESCRIPTION**
13 **DRUGS TOWARD THE ANNUAL OUT OF POCK-**
14 **ET THRESHOLD UNDER PART D.**

15 (a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the
16 Social Security Act (42 U.S.C. 1395w-102(b)(4)(C)) is
17 amended—

18 (1) in clause (i), by striking “and” at the end;

19 (2) in clause (ii)—

20 (A) by striking “such costs shall be treated
21 as incurred only if” and inserting “subject to
22 clause (iii), such costs shall be treated as in-
23 curred only if”;

1 (B) by striking “, under section 1860D–
2 14, or under a State Pharmaceutical Assistance
3 Program”; and

4 (C) by striking the period at the end and
5 inserting “; and”; and

6 (3) by inserting after clause (ii) the following
7 new clause:

8 “(iii) such costs shall be treated as in-
9 curred and shall not be considered to be
10 reimbursed under clause (ii) if such costs
11 are borne or paid—

12 “(I) under section 1860D–14;

13 “(II) under a State Pharma-
14 ceutical Assistance Program;

15 “(III) by the Indian Health Serv-
16 ice, an Indian tribe or tribal organiza-
17 tion, or an urban Indian organization
18 (as defined in section 4 of the Indian
19 Health Care Improvement Act); or

20 “(IV) under an AIDS Drug As-
21 sistance Program under part B of
22 title XXVI of the Public Health Serv-
23 ice Act.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to costs incurred on or after
3 January 1, 2009.

4 **SEC. 222. PERMITTING MID-YEAR CHANGES IN ENROLL-**
5 **MENT FOR FORMULARY CHANGES AD-**
6 **VERSELY IMPACT AN ENROLLEE.**

7 (a) IN GENERAL.—Section 1860D–1(b)(3) of the So-
8 cial Security Act (42 U.S.C. 1395w–101(b)(3)) is amended
9 by adding at the end the following new subparagraph:

10 “(F) CHANGE IN FORMULARY RESULTING
11 IN INCREASE IN COST-SHARING.—

12 “(i) IN GENERAL.—Except as pro-
13 vided in clause (ii), in the case of an indi-
14 vidual enrolled in a prescription drug plan
15 (or MA–PD plan) who has been prescribed
16 a covered part D drug while so enrolled, if
17 the formulary of the plan is materially
18 changed (other than at the end of a con-
19 tract year) so to reduce the coverage (or
20 increase the cost-sharing) of the drug
21 under the plan.

22 “(ii) EXCEPTION.—Clause (i) shall
23 not apply in the case that a drug is re-
24 moved from the formulary of a plan be-
25 cause of a recall or withdrawal of the drug

1 issued by the Food and Drug Administra-
2 tion.”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to contract years beginning on
5 or after January 1, 2009.

6 **SEC. 223. REMOVAL OF EXCLUSION OF BENZODIAZEPINES**
7 **FROM REQUIRED COVERAGE UNDER THE**
8 **MEDICARE PRESCRIPTION DRUG PROGRAM.**

9 (a) IN GENERAL.—Section 1860D–2(e)(2)(A) of the
10 Social Security Act (42 U.S.C. 1395w-102(e)(2)(A)) is
11 amended—

12 (1) by striking “subparagraph (E)” and insert-
13 ing “subparagraphs (E) and (J)”; and

14 (2) by inserting “and benzodiazepines, respec-
15 tively” after “smoking cessation agents”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 subsection (a) shall apply to prescriptions dispensed on or
18 after January 1, 2009.

19 **SEC. 224. PERMITTING UPDATING DRUG COMPENDIA**
20 **UNDER PART D USING PART B UPDATE PROC-**
21 **ESS.**

22 Section 1860D–4(b)(3)(C) of the Social Security Act
23 (42 U.S.C. 1395w-104(b)(3)(C)) is amended by adding at
24 the end the following new clause:

1 “(iv) UPDATING DRUG COMPENDIA
2 USING PART B PROCESS.—The Secretary
3 may apply under this subparagraph the
4 same process for updating drug compendia
5 that is used for purposes of section
6 1861(t)(2)(B)(ii).”.

7 **SEC. 225. CODIFICATION OF SPECIAL PROTECTIONS FOR**
8 **SIX PROTECTED DRUG CLASSIFICATIONS.**

9 (a) IN GENERAL.—Section 1860D–4(b)(3) of the So-
10 cial Security Act (42 U.S.C. 1395w-104(b)(3)) is amend-
11 ed—

12 (1) in subparagraph (C)(i), by inserting “, ex-
13 cept as provided in subparagraph (G),” after “al-
14 though”; and

15 (2) by inserting after subparagraph (F) the fol-
16 lowing new subparagraph:

17 “(G) REQUIRED INCLUSION OF DRUGS IN
18 CERTAIN THERAPEUTIC CLASSES.—

19 “(i) IN GENERAL.—The formulary
20 must include all or substantially all covered
21 part D drugs in each of the following
22 therapeutic classes of covered part D
23 drugs:

24 “(I) Anticonvulsants.

25 “(II) Antineoplastics.

1 “(III) Antiretrovirals.

2 “(IV) Antidepressants.

3 “(V) Antipsychotics.

4 “(VI) Immunosuppressants.

5 “(ii) USE OF UTILIZATION MANAGE-
6 MENT TOOLS.—A PDP sponsor of a pre-
7 scription drug plan may use prior author-
8 ization or step therapy for the initiation of
9 medications within one of the classifica-
10 tions specified in clause (i) but only when
11 approved by the Secretary, except that
12 such prior authorization or step therapy
13 may not be used in the case of
14 antiretrovirals and in the case of individ-
15 uals who already are stabilized on a drug
16 treatment regimen.”.

17 (b) EFFECTIVE DATE.—The amendment made by
18 subsection (a) shall apply for plan years beginning on or
19 after January 1, 2009.

20 **SEC. 226. ELIMINATION OF MEDICARE PART D LATE EN-**
21 **ROLLMENT PENALTIES PAID BY LOW-INCOME**
22 **SUBSIDY-ELIGIBLE INDIVIDUALS.**

23 (a) INDIVIDUALS WITH INCOME BELOW 135 PER-
24 CENT OF POVERTY LINE.—Paragraph (1)(A)(ii) of sec-

tion 1860D-14(a) of the Social Security Act (42 U.S.C. 1395w-114(a)) is amended to read as follows:

“(ii) 100 percent of any late enrollment penalties imposed under section 1860D-13(b) for such individual.”.

(b) INDIVIDUALS WITH INCOME BETWEEN 135 AND 150 PERCENT OF POVERTY LINE.—Paragraph (2)(A) of such section is amended—

(1) by inserting “equal to (i) an amount” after “premium subsidy”;

(2) by striking “paragraph (1)(A)” and inserting “clause (i) of paragraph (1)(A)”;

(3) by adding at the end before the period the following: “, plus (ii) 100 percent of the amount described in clause (ii) of such paragraph for such individual”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to subsidies for months beginning with January 2008.

SEC. 227. SPECIAL ENROLLMENT PERIOD FOR SUBSIDY ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 1860D-1(b)(3) of the Social Security Act (42 U.S.C. 1395w-101(b)(3)), as amended by section 222(a), is further amended by adding at the end the following new subparagraph:

1 “(G) ELIGIBILITY FOR LOW-INCOME SUB-
2 SIDY.—

3 “(i) IN GENERAL.—In the case of an
4 applicable subsidy eligible individual (as
5 defined in clause (ii)), the special enroll-
6 ment period described in clause (iii).

7 “(ii) APPLICABLE SUBSIDY ELIGIBLE
8 INDIVIDUAL DEFINED.—For purposes of
9 this subparagraph, the term ‘applicable
10 subsidy eligible individual’ means a part D
11 eligible individual who is determined under
12 subparagraph (B) of section 1860D–
13 14(a)(3) to be a subsidy eligible individual
14 (as defined in subparagraph (A) of such
15 section), and includes such an individual
16 who was enrolled in a prescription drug
17 plan or an MA–PD plan on the date of
18 such determination.

19 “(iii) SPECIAL ENROLLMENT PERIOD
20 DESCRIBED.—The special enrollment pe-
21 riod described in this clause, with respect
22 to an applicable subsidy eligible individual,
23 is the 90-day period beginning on the date
24 the individual receives notification that
25 such individual has been determined under

1 section 1860D-14(a)(3)(B) to be a subsidy
2 eligible individual (as so defined).”.

3 (b) AUTOMATIC ENROLLMENT PROCESS FOR CER-
4 TAIN SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D-
5 1(b)(1) of the Social Security Act (42 U.S.C. 1395w-
6 101(b)(1)), as amended by section 218(a)(2), is further
7 amended by adding at the end the following new subpara-
8 graph:

9 “(E) SPECIAL RULE FOR SUBSIDY ELIGI-
10 BLE INDIVIDUALS.—The process established
11 under subparagraph (A) shall include, in the
12 case of an applicable subsidy eligible individual
13 (as defined in clause (ii) of paragraph (3)(F))
14 who fails to enroll in a prescription drug plan
15 or an MA-PD plan during the special enroll-
16 ment period described in clause (iii) of such
17 paragraph applicable to such individual, a proc-
18 ess for the facilitated enrollment of the indi-
19 vidual in the prescription drug plan or MA-PD
20 plan that is most appropriate for such indi-
21 vidual (as determined by the Secretary). Noth-
22 ing in the previous sentence shall prevent an in-
23 dividual described in such sentence from declin-
24 ing enrollment in a plan determined appropriate

1 by the Secretary (or in the program under this
2 part) or from changing such enrollment.”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to subsidy determinations made
5 for months beginning with January 2008.

6 **Subtitle D—Reducing Health**
7 **Disparities**

8 **SEC. 231. MEDICARE DATA ON RACE, ETHNICITY, AND PRI-**
9 **MARY LANGUAGE.**

10 (a) REQUIREMENTS.—

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services (in this subtitle referred to as the
13 “Secretary”) shall—

14 (A) collect data on the race, ethnicity, and
15 primary language of each applicant for and re-
16 cipient of benefits under title XVIII of the So-
17 cial Security Act—

18 (i) using, at a minimum, the cat-
19 egories for race and ethnicity described in
20 the 1997 Office of Management and Budg-
21 et Standards for Maintaining, Collecting,
22 and Presenting Federal Data on Race and
23 Ethnicity;

(ii) using the standards developed under subsection (e) for the collection of language data;

(iii) where practicable, collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories; and

(iv) where practicable, through self-reporting;

(B) with respect to the collection of the data described in subparagraph (A) for applicants and recipients who are minors or otherwise legally incapacitated, require that—

(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

(ii) the preferred language of the parent or legal guardian of such an applicant or recipient be collected;

(C) systematically analyze at least annually such data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities in health and health care and when appropriate, for men and women separately;

1 (D) report the results of analysis annually
2 to the Director of the Office for Civil Rights,
3 the Committee on Health, Education, Labor,
4 and Pensions and the Committee on Finance of
5 the Senate, and the Committee on Energy and
6 Commerce and the Committee on Ways and
7 Means of the House of Representatives; and

8 (E) ensure that the provision of assistance
9 to an applicant or recipient of assistance is not
10 denied or otherwise adversely affected because
11 of the failure of the applicant or recipient to
12 provide race, ethnicity, and primary language
13 data.

14 (2) RULES OF CONSTRUCTION.—Nothing in
15 this subsection shall be construed—

16 (A) to permit the use of information col-
17 lected under this subsection in a manner that
18 would adversely affect any individual providing
19 any such information; and

20 (B) to require health care providers to col-
21 lect data.

22 (b) PROTECTION OF DATA.—The Secretary shall en-
23 sure (through the promulgation of regulations or other-
24 wise) that all data collected pursuant to subsection (a) is
25 protected—

1 (1) under the same privacy protections as the
2 Secretary applies to other health data under the reg-
3 ulations promulgated under section 264(e) of the
4 Health Insurance Portability and Accountability Act
5 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
6 lating to the privacy of individually identifiable
7 health information and other protections; and

8 (2) from all inappropriate internal use by any
9 entity that collects, stores, or receives the data, in-
10 cluding use of such data in determinations of eligi-
11 bility (or continued eligibility) in health plans, and
12 from other inappropriate uses, as defined by the
13 Secretary.

14 (c) COLLECTION PLAN.—In carrying out the duties
15 specified in subsection (a), the Secretary shall develop and
16 implement a plan to improve the collection, analysis, and
17 reporting of racial, ethnic, and primary language data
18 within the programs administered under title XVIII of the
19 Social Security Act, and, in consultation with the National
20 Committee on Vital Health Statistics, the Office of Minor-
21 ity Health, and other appropriate public and private enti-
22 ties, shall make recommendations on how to—

23 (1) implement subsection (a) while minimizing
24 the cost and administrative burdens of data collec-
25 tion and reporting;

1 (2) expand awareness that data collection, anal-
2 ysis, and reporting by race, ethnicity, and primary
3 language is legal and necessary to assure equity and
4 non-discrimination in the quality of health care serv-
5 ices;

6 (3) ensure that future patient record systems
7 have data code sets for racial, ethnic, and primary
8 language identifiers and that such identifiers can be
9 retrieved from clinical records, including records
10 transmitted electronically;

11 (4) improve health and health care data collec-
12 tion and analysis for more population groups if such
13 groups can be aggregated into the minimum race
14 and ethnicity categories;

15 (5) provide researchers with greater access to
16 racial, ethnic, and primary language data, subject to
17 privacy and confidentiality regulations; and

18 (6) safeguard and prevent the misuse of data
19 collected under subsection (a).

20 (d) COMPLIANCE WITH STANDARDS.—Data collected
21 under subsection (a) shall be obtained, maintained, and
22 presented (including for reporting purposes and at a min-
23 imum) in accordance with the 1997 Office of Management
24 and Budget Standards for Maintaining, Collecting, and
25 Presenting Federal Data on Race and Ethnicity.

(e) LANGUAGE COLLECTION STANDARDS.—Not later than 1 year after the date of enactment of this Act, the Director of the Office of Minority Health, in consultation with the Office for Civil Rights of the Department of Health and Human Services, shall develop and disseminate Standards for the Classification of Federal Data on Preferred Written and Spoken Language.

(f) TECHNICAL ASSISTANCE FOR THE COLLECTION AND REPORTING OF DATA.—

(1) IN GENERAL.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a health care provider or plan operating under the Medicare program to comply with the requirements of this section.

(2) TYPES OF ASSISTANCE.—Assistance provided under this subsection may include assistance to—

(A) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis;

(B) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be

1 aggregated into the minimum race and ethnicity
2 categories;

3 (C) develop mechanisms for submitting col-
4 lected data subject to existing privacy and con-
5 fidentiality regulations; and

6 (D) develop educational programs to raise
7 awareness that data collection and reporting by
8 race, ethnicity, and preferred language are legal
9 and essential for eliminating health and health
10 care disparities.

11 (g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The
12 Secretary, acting through the Director of the Agency for
13 Health Care Research and Quality and in coordination
14 with the Administrator of the Centers for Medicare &
15 Medicaid Services, shall—

16 (1) identify appropriate quality assurance mech-
17 anisms to monitor for health disparities under the
18 Medicare program;

19 (2) specify the clinical, diagnostic, or thera-
20 peutic measures which should be monitored;

21 (3) develop new quality measures relating to ra-
22 cial and ethnic disparities in health and health care;

23 (4) identify the level at which data analysis
24 should be conducted; and

1 (5) share data with external organizations for
2 research and quality improvement purposes, in com-
3 pliance with applicable Federal privacy laws.

4 (h) REPORT.—Not later than 2 years after the date
5 of enactment of this Act, and biennially thereafter, the
6 Secretary shall submit to the appropriate committees of
7 Congress a report on the effectiveness of data collection,
8 analysis, and reporting on race, ethnicity, and primary
9 language under the programs administered through title
10 XVIII of the Social Security Act. The report shall evaluate
11 the progress made with respect to the plan under sub-
12 section (c) or subsequent revisions thereto.

13 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
14 authorized to be appropriated to carry out this section,
15 such sums as may be necessary for each of fiscal years
16 2008 through 2012.

17 **SEC. 232. ENSURING EFFECTIVE COMMUNICATION IN MEDI-**
18 **CARE.**

19 (a) ENSURING EFFECTIVE COMMUNICATION BY THE
20 CENTERS FOR MEDICARE & MEDICAID SERVICES.—

21 (1) STUDY ON MEDICARE PAYMENTS FOR LAN-
22 GUAGE SERVICES.—The Secretary of Health and
23 Human Services shall conduct a study that examines
24 ways that Medicare should develop payment systems

1 for language services using the results of the dem-
2 onstration program conducted under section 233.

3 (2) ANALYSES.— The study shall include an
4 analysis of each of the following:

5 (A) How to develop and structure appro-
6 priate payment systems for language services
7 for all Medicare service providers.

8 (B) The feasibility of adopting a payment
9 methodology for on-site interpreters, including
10 interpreters who work as independent contrac-
11 tors and interpreters who work for agencies
12 that provide on-site interpretation, pursuant to
13 which such interpreters could directly bill Medi-
14 care for services provided in support of physi-
15 cian office services for an LEP Medicare pa-
16 tient.

17 (C) The feasibility of Medicare contracting
18 directly with agencies that provide off-site inter-
19 pretation including telephonic and video inter-
20 pretation pursuant to which such contractors
21 could directly bill Medicare for the services pro-
22 vided in support of physician office services for
23 an LEP Medicare patient.

24 (D) The feasibility of modifying the exist-
25 ing Medicare resource-based relative value scale

1 (RBRVS) by using adjustments (such as multi-
2 pliers or add-ons) when a patient is LEP.

3 (E) How each of options described in a
4 previous paragraph would be funded and how
5 such funding would affect physician payments,
6 a physician's practice, and beneficiary cost-
7 sharing.

8 (3) VARIATION IN PAYMENT SYSTEM DE-
9 SCRIBED.—The payment systems described in sub-
10 section (b) may allow variations based upon types of
11 service providers, available delivery methods, and
12 costs for providing language services including such
13 factors as—

14 (A) the type of language services provided
15 (such as provision of health care or health care
16 related services directly in a non-English lan-
17 guage by a bilingual provider or use of an inter-
18 preter);

19 (B) type of interpretation services provided
20 (such as in-person, telephonic, video interpreta-
21 tion);

22 (C) the methods and costs of providing
23 language services (including the costs of pro-
24 viding language services with internal staff or

1 through contract with external independent con-
2 tractors and/or agencies);

3 (D) providing services for languages not
4 frequently encountered in the United States;
5 and

6 (E) providing services in rural areas.

7 (4) REPORT.—The Secretary shall submit a re-
8 port on the study conducted under subsection (a) to
9 appropriate committees of Congress not later than 1
10 year after the expiration of the demonstration pro-
11 gram conducted under section 3.

12 (b) HEALTH PLANS.—Section 1857(g)(1) of the So-
13 cial Security Act (42 U.S.C. 1395w-27(g)(1)) is amend-
14 ed—

15 (1) by striking “or” at the end of subparagraph
16 (F’);

17 (2) by adding “and” at the end of subpara-
18 graph (G); and

19 (3) by inserting after subparagraph (G) the fol-
20 lowing new subparagraph:

21 “(H) fails substantially to provide lan-
22 guage services to limited English proficient
23 beneficiaries enrolled in the plan that are re-
24 quired under law;”.

1 **SEC. 233. DEMONSTRATION TO PROMOTE ACCESS FOR**
2 **MEDICARE BENEFICIARIES WITH LIMITED**
3 **ENGLISH PROFICIENCY BY PROVIDING REIM-**
4 **BURSEMENT FOR CULTURALLY AND LINGUIS-**
5 **TICALLY APPROPRIATE SERVICES.**

6 (a) IN GENERAL.—Within one year after the date of
7 the enactment of this Act the Secretary, acting through
8 the Centers for Medicare & Medicaid Services, shall award
9 24 3-year demonstration grants to eligible Medicare serv-
10 ice providers to improve effective communication between
11 such providers and Medicare beneficiaries who are limited
12 English proficient. The Secretary shall not authorize a
13 grant larger than \$500,000 over three years for any grant-
14 ee.

15 (b) ELIGIBILITY; PRIORITY.—

16 (1) ELIGIBILITY.—To be eligible to receive a
17 grant under subsection (1) an entity shall—

18 (A) be—

19 (i) a provider of services under part A
20 of title XVIII of the Social Security Act;

21 (ii) a service provider under part B of
22 such title;

23 (iii) a part C organization offering a
24 Medicare part C plan under part C of such
25 title; or

1 (iv) a PDP sponsor of a prescription
2 drug plan under part D of such title; and
3 (B) prepare and submit to the Secretary
4 an application, at such time, in such manner,
5 and accompanied by such additional informa-
6 tion as the Secretary may require.

7 (2) PRIORITY.—

8 (A) DISTRIBUTION.—To the extent fea-
9 sible, in awarding grants under this section, the
10 Secretary shall award—

11 (i) 6 grants to providers of services
12 described in paragraph (1)(A)(i);

13 (ii) 6 grants to service providers de-
14 scribed in paragraph (1)(A)(ii);

15 (iii) 6 grants to organizations de-
16 scribed in paragraph (1)(A)(iii); and

17 (iv) 6 grants to sponsors described in
18 paragraph (1)(A)(iv).

19 (B) FOR COMMUNITY ORGANIZATIONS.—
20 The Secretary shall give priority to applicants
21 that have developed partnerships with commu-
22 nity organizations or with agencies with experi-
23 ence in language access.

24 (C) VARIATION IN GRANTEES.—The Sec-
25 retary shall also ensure that the grantees under

1 this section represent, among other factors,
2 variations in—

3 (i) different types of service providers
4 and organizations under parts A through
5 D of title XVIII of the Social Security Act;

6 (ii) languages needed and their fre-
7 quency of use;

8 (iii) urban and rural settings;

9 (iv) at least two geographic regions;
10 and

11 (v) at least two large metropolitan
12 statistical areas with diverse populations.

13 (c) USE OF FUNDS.—

14 (1) IN GENERAL.—A grantee shall use grant
15 funds received under this section to pay for the pro-
16 vision of competent language services to Medicare
17 beneficiaries who are limited English proficient.
18 Competent interpreter services may be provided
19 through on-site interpretation, telephonic interpreta-
20 tion, or video interpretation or direct provision of
21 health care or health care related services by a bilin-
22 gual health care provider. A grantee may use bilin-
23 gual providers, staff, or contract interpreters. A
24 grantee may use grant funds to pay for competent
25 translation services. A grantee may use up to 10

percent of the grant funds to pay for administrative costs associated with the provision of competent language services and for reporting required under subsection (E).

(2) ORGANIZATIONS.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) DETERMINATION OF PAYMENTS FOR LANGUAGE SERVICES.—Payments to grantees shall be calculated based on the estimated numbers of LEP Medicare beneficiaries in a grantee's service area utilizing—

(A) data on the numbers of limited English proficient individuals who speak English less than “very well” from the most recently available data from the Bureau of the Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of LEP individuals served by the grantee; or

(B) the grantee's own data if the grantee routinely collects data on Medicare beneficiaries' primary language in a manner determined by the Secretary to yield accurate data and such data shows greater numbers of LEP individuals than the data listed in subparagraph (A).

(4) LIMITATIONS.—

(A) REPORTING.—Payments shall only be provided under this section to grantees that report their costs of providing language services as required under subsection (e). If a grantee fails to provide the reports under such section for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

(B) TYPE OF SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), payments shall be provided under this section only to grantees that utilize competent bilingual staff or competent interpreter or translation services which—

(I) if the grantee operates in a State that has statewide health care

1 interpreter standards, meet the State
2 standards currently in effect; or

3 (II) if the grantee operates in a
4 State that does not have statewide
5 health care interpreter standards, uti-
6 lizes competent interpreters who fol-
7 low the National Council on Inter-
8 preting in Health Care's Code of Eth-
9 ics and Standards of Practice.

10 (ii) EXEMPTIONS.—The requirements
11 of clause (i) shall not apply—

12 (I) in the case of a Medicare ben-
13 eficiary who is limited English pro-
14 ficient (who has been informed in the
15 beneficiary's primary language of the
16 availability of free interpreter and
17 translation services) and who requests
18 the use of family, friends, or other
19 persons untrained in interpretation or
20 translation and the grantee documents
21 the request in the beneficiary's record;
22 and

23 (II) in the case of a medical
24 emergency where the delay directly as-
25 sociated with obtaining a competent

1 interpreter or translation services
2 would jeopardize the health of the pa-
3 tient.

4 Nothing in clause (ii)(II) shall be con-
5 strued to exempt an emergency rooms or
6 similar entities that regularly provide
7 health care services in medical emergencies
8 from having in place systems to provide
9 competent interpreter and translation serv-
10 ices without undue delay.

11 (d) ASSURANCES.—Grantees under this section
12 shall—

13 (1) ensure that appropriate clinical and support
14 staff receive ongoing education and training in lin-
15 guistically appropriate service delivery; ensure the
16 linguistic competence of bilingual providers;

17 (2) offer and provide appropriate language serv-
18 ices at no additional charge to each patient with lim-
19 ited English proficiency at all points of contact, in
20 a timely manner during all hours of operation;

21 (3) notify Medicare beneficiaries of their right
22 to receive language services in their primary lan-
23 guage;

1 (4) post signage in the languages of the com-
2 monly encountered group or groups present in the
3 service area of the organization; and

4 (5) ensure that—

5 (A) primary language data are collected
6 for recipients of language services; and

7 (B) consistent with the privacy protections
8 provided under the regulations promulgated
9 pursuant to section 264(c) of the Health Insur-
10 ance Portability and Accountability Act of 1996
11 (42 U.S.C. 1320d-2 note), if the recipient of
12 language services is a minor or is incapacitated,
13 the primary language of the parent or legal
14 guardian is collected and utilized.

15 (e) REPORTING REQUIREMENTS.—Grantees under
16 this section shall provide the Secretary with reports at the
17 conclusion of the each year of a grant under this section.
18 each report shall include at least the following informa-
19 tion:

20 (1) The number of Medicare beneficiaries to
21 whom language services are provided.

22 (2) The languages of those Medicare bene-
23 ficiaries.

24 (3) The types of language services provided
25 (such as provision of services directly in non-English

1 language by a bilingual health care provider or use
2 of an interpreter).

3 (4) Type of interpretation (such as in-person,
4 telephonic, or video interpretation).

5 (5) The methods of providing language services
6 (such as staff or contract with external independent
7 contractors or agencies).

8 (6) The length of time for each interpretation
9 encounter.

10 (7) The costs of providing language services
11 (which may be actual or estimated, as determined by
12 the Secretary).

13 (f) NO COST SHARING.—LEP Beneficiaries shall not
14 have to pay cost-sharing or co-pays for language services
15 provided through this demonstration program.

16 (g) EVALUATION AND REPORT.—The Secretary shall
17 conduct an evaluation of the demonstration program
18 under this section and shall submit to the appropriate
19 committees of Congress a report not later than 1 year
20 after the completion of the program. The report shall in-
21 clude the following:

22 (1) An analysis of the patient outcomes and
23 costs of furnishing care to the LEP Medicare bene-
24 ficiaries participating in the project as compared to

1 such outcomes and costs for limited English pro-
2 ficient Medicare beneficiaries not participating.

3 (2) The effect of delivering culturally and lin-
4 guistically appropriate services on beneficiary access
5 to care, utilization of services, efficiency and cost-ef-
6 fectiveness of health care delivery, patient satisfac-
7 tion, and select health outcomes.

8 (3) Recommendations regarding the extension
9 of such project to the entire Medicare program.

10 (h) GENERAL PROVISIONS.—Nothing in this section
11 shall be construed to limit otherwise existing obligations
12 of recipients of Federal financial assistance under title VI
13 of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et.
14 seq.) or any other statute.

15 (i) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section
17 \$10,000,000 for each fiscal year of the demonstration.

18 **SEC. 234. DEMONSTRATION TO IMPROVE CARE TO PRE-**
19 **VIOUSLY UNINSURED.**

20 (a) ESTABLISHMENT.—Within one year after the
21 date of enactment of this Act, the Secretary shall establish
22 a demonstration project to determine the greatest needs
23 and most effective methods of outreach to medicare bene-
24 ficiaries who were previously uninsured.

(b) SCOPE.—The demonstration shall be in no fewer than 10 sites, and shall include state health insurance assistance programs, community health centers, community-based organizations, community health workers, and other service providers under parts A, B, and C of title XVIII of the Social Security Act. Grantees that are plans operating under part C shall document that enrollees who were previously uninsured receive the “Welcome to Medicare” physical exam.

(c) DURATION.—The Secretary shall conduct the demonstration project for a period of 2 years.

(d) REPORT AND EVALUATION.—The Secretary shall conduct an evaluation of the demonstration and not later than 1 year after the completion of the project shall submit to Congress a report including the following:

(1) An analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, such as revising outreach and enrollment materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the Medicare and You handbook.

(2) The effect of such outreach on beneficiary access to care, utilization of services, efficiency and

1 cost-effectiveness of health care delivery, patient sat-
2 isfaction, and select health outcomes.

3 **SEC. 235. OFFICE OF THE INSPECTOR GENERAL REPORT**
4 **ON COMPLIANCE WITH AND ENFORCEMENT**
5 **OF NATIONAL STANDARDS ON CULTURALLY**
6 **AND LINGUISTICALLY APPROPRIATE SERV-**
7 **ICES (CLAS) IN MEDICARE.**

8 (a) REPORT.—Not later than two years after the date
9 of the enactment of this Act, the Inspector General of the
10 Department of Health and Human Services shall prepare
11 and publish a report on—

12 (1) the extent to which Medicare providers and
13 plans are complying with the Office for Civil Rights'
14 Guidance to Federal Financial Assistance Recipients
15 Regarding Title VI Prohibition Against National Or-
16 igin Discrimination Affecting Limited English Pro-
17 ficient Persons and the Office of Minority Health's
18 Culturally and Linguistically Appropriate Services
19 Standards in health care; and

20 (2) a description of the costs associated with or
21 savings related to the provision of language services.
22 Such report shall include recommendations on improving
23 compliance with CLAS Standards and recommendations
24 on improving enforcement of CLAS Standards.

(b) IMPLEMENTATION.—Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.

SEC. 236. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall seek to enter into an arrangement with the Institute of under which the Institute will prepare and publish, not later than 3 years after the date of the enactment of this Act, a report on the impact of language access services on the health and health care of limited English proficient populations.

(b) CONTENTS.—Such report shall include—

(1) recommendations on the development and implementation of policies and practices by health care organizations and providers for limited English proficient patient populations;

(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and

(3) a description of the costs associated with or savings related to provision of language access services.

1 **SEC. 237. DEFINITIONS.**

2 In this subtitle:

3 (1) **BILINGUAL.**—The term “bilingual” with re-
4 spect to an individual means a person who has suffi-
5 cient degree of proficiency in two languages and can
6 ensure effective communication can occur in both
7 languages.

8 (2) **COMPETENT INTERPRETER SERVICES.**—The
9 term “competent interpreter services” means a
10 trans-language rendition of a spoken message in
11 which the interpreter comprehends the source lan-
12 guage and can speak comprehensively in the target
13 language to convey the meaning intended in the
14 source language. The interpreter knows health and
15 health-related terminology and provides accurate in-
16 terpretations by choosing equivalent expressions that
17 convey the best matching and meaning to the source
18 language and captures, to the greatest possible ex-
19 tent, all nuances intended in the source message.

20 (3) **COMPETENT TRANSLATION SERVICES.**—The
21 term “competent translation services” means a
22 trans-language rendition of a written document in
23 which the translator comprehends the source lan-
24 guage and can write comprehensively in the target
25 language to convey the meaning intended in the
26 source language. The translator knows health and

1 health-related terminology and provides accurate
2 translations by choosing equivalent expressions that
3 convey the best matching and meaning to the source
4 language and captures, to the greatest possible extent,
5 all nuances intended in the source document.

6 (4) EFFECTIVE COMMUNICATION.—The term
7 “effective communication” means an exchange of information
8 between the provider of health care or
9 health care-related services and the limited English
10 proficient recipient of such services that enables limited
11 English proficient individuals to access, understand,
12 and benefit from health care or health care-related
13 services.

14 (5) INTERPRETING/INTERPRETATION.—The
15 terms “interpreting” and “interpretation” mean the
16 transmission of a spoken message from one language
17 into another, faithfully, accurately, and objectively.

18 (6) HEALTH CARE SERVICES.—The term
19 “health care services” means services that address
20 physical as well as mental health conditions in all
21 care settings.

22 (7) HEALTH CARE-RELATED SERVICES.—The
23 term “health care-related services” means human or
24 social services programs or activities that provide access,
25 referrals or links to health care.

1 (8) LANGUAGE ACCESS.—The term “language
2 access” means the provision of language services to
3 an LEP individual designed to enhance that individ-
4 ual’s access to, understanding of or benefit from
5 health care or health care-related services.

6 (9) LANGUAGE SERVICES.—The term “lan-
7 guage services” means provision of health care serv-
8 ices directly in a non-English language, interpreta-
9 tion, translation, and non-English signage.

10 (10) LIMITED ENGLISH PROFICIENT.—The
11 term “limited English proficient” or “LEP” with re-
12 spect to an individual means an individual who
13 speaks a primary language other than English and
14 who cannot speak, read, write or understand the
15 English language at a level that permits the indi-
16 vidual to effectively communicate with clinical or
17 nonclinical staff at an entity providing health care or
18 health care related services.

19 (11) MEDICARE PROGRAM.—The term “Medi-
20 care program” means the programs under parts A
21 through D of title XVIII of the Social Security Act.

22 (12) SERVICE PROVIDER.—The term “service
23 provider” includes all suppliers, providers of services,
24 or entities under contract to provide coverage, items

1 or services under any part of title XVIII of the So-
2 cial Security Act.

3 **TITLE III—PHYSICIANS’ SERVICE**
4 **PAYMENT REFORM**

5 **SEC. 301. ESTABLISHMENT OF SEPARATE TARGET GROWTH**
6 **RATES FOR SERVICE CATEGORIES.**

7 (a) ESTABLISHMENT OF SERVICE CATEGORIES.—
8 Subsection (j) of section 1848 of the Social Security Act
9 (42 U.S.C. 1395w-4) is amended by adding at the end
10 the following new paragraph:

11 “(5) SERVICE CATEGORIES.—For services fur-
12 nished on or after January 1, 2008, each of the fol-
13 lowing categories of physicians’ services shall be
14 treated as a separate ‘service category’:

15 “(A) Evaluation and management services
16 for primary care (including new and established
17 patient office visits delivered by physicians who
18 the Secretary determines provide accessible,
19 continuous, coordinated, and comprehensive
20 care for Medicare beneficiaries, emergency de-
21 partment visits, and home visits), and for pre-
22 ventive services (including screening mammog-
23 raphy, colorectal cancer screening, and other
24 services as defined by the Secretary, limited to

1 the recommendations of the United States Pre-
2 ventive Services Task Force).

3 “(B) Evaluation and management services
4 not described in subparagraph (A).

5 “(C) Imaging services (as defined in sub-
6 section (b)(4)(B)) and diagnostic tests (other
7 than clinical diagnostic laboratory tests) not de-
8 scribed in subparagraph (A).

9 “(D) Procedures that are subject (under
10 regulations promulgated to carry out this sec-
11 tion) to a 10-day or 90-day global period (in
12 this paragraph referred to as ‘major proce-
13 dures’), except that the Secretary may reclas-
14 sify as minor procedures under subparagraph
15 (F) any procedures that would otherwise be in-
16 cluded in this category if the Secretary deter-
17 mines that such procedures are not major pro-
18 cedures.

19 “(E) Anesthesia services that are paid on
20 the basis of the separate conversion factor for
21 anesthesia services determined under subsection
22 (d)(1)(D).

23 “(F) Minor procedures and any other phy-
24 sicians’ services that are not described in a pre-
25 ceding subparagraph.”

1 (b) ESTABLISHMENT OF SEPARATE CONVERSION
2 FACTORS FOR EACH SERVICE CATEGORY.—Subsection

3 (d)(1) of section 1848 of the Social Security Act (42
4 U.S.C. 1395w-4) is amended—

5 (1) in subparagraph (A)—

6 (A) by designating the sentence beginning
7 “The conversion factor” as clause (i) with the
8 heading “APPLICATION OF SINGLE CONVERSION
9 FACTOR” and with appropriate indentation;

10 (B) by striking “The conversion factor”
11 and inserting “Subject to clause (ii), the con-
12 version factor”; and

13 (C) by adding at the end the following new
14 clause:

15 “(ii) APPLICATION OF MULTIPLE CON-
16 VERSION FACTORS BEGINNING WITH
17 2008.—

18 “(I) IN GENERAL.—In applying
19 clause (i) for years beginning with
20 2008, separate conversion factors
21 shall be established for each service
22 category of physicians’ services (as de-
23 fined in subsection (j)(5)) and any
24 reference in this section to a conver-
25 sion factor for such years shall be

deemed to be a reference to the conversion factor for each of such categories.

“(II) INITIAL CONVERSION FACTORS; SPECIAL RULE FOR ANESTHESIA SERVICES.— Such factors for 2008 shall be based upon the single conversion factor for 2007 multiplied by the update established under paragraph (8) for such category for 2008. In the case of the service category described in subsection (j)(5)(F) (relating to anesthesia services), the conversion factor for 2008 shall be based on the separate conversion factor specified in subparagraph (D) for 2007 multiplied by the update established under paragraph (8) for such category for 2008.

“(III) UPDATING OF CONVERSION FACTORS.— Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the update

1 established for such category under
2 paragraph (8) for the year involved.”;
3 and

4 (2) in subparagraph (D), by inserting “(before
5 2008)” after “for a year”.

6 (c) ESTABLISHING UPDATES FOR CONVERSION FAC-
7 TORS FOR SERVICE CATEGORIES.—Section 1848(d) of the
8 Social Security Act (42 U.S.C. 1395w-4(d)) is amended—

9 (1) in paragraph (4)(B), by striking “and (6)”
10 and inserting “, (6), and (8)”;

11 (2) in paragraph (4)(C)(iii), by striking “The
12 allowed” and inserting “Subject to paragraph
13 (8)(B), the allowed”;

14 (3) in paragraph (4)(D), by striking “The up-
15 date” and inserting “Subject to paragraph (8)(E),
16 the update”; and

17 (4) by adding at the end the following new
18 paragraphs:

19 “(8) UPDATES FOR SERVICE CATEGORIES BE-
20 GINNING WITH 2008.—

21 “(A) IN GENERAL.—In applying paragraph
22 (4) for a year beginning with 2008, the fol-
23 lowing rules apply:

24 “(i) APPLICATION OF SEPARATE UP-
25 DATE ADJUSTMENTS FOR EACH SERVICE

1 CATEGORY.—Pursuant to paragraph
2 (1)(A)(ii)(I), the update shall be made to
3 the conversion factor for each service cat-
4 egory (as defined in subsection (j)(5))
5 based upon an update adjustment factor
6 for the respective category and year and
7 the update adjustment factor shall be com-
8 puted, for a year, separately for each serv-
9 ice category.

10 “(ii) COMPUTATION OF ALLOWED AND
11 ACTUAL EXPENDITURES BASED ON SERV-
12 ICE CATEGORIES.—In computing the prior
13 year adjustment component and the cumu-
14 lative adjustment component under clauses
15 (i) and (ii) of paragraph (4)(B), the fol-
16 lowing rules apply:

17 “(I) APPLICATION BASED ON
18 SERVICE CATEGORIES.—The allowed
19 expenditures and actual expenditures
20 shall be the allowed and actual ex-
21 penditures for the service category, as
22 determined under subparagraph (B).

23 “(II) LIMITATION TO PHYSICIAN
24 FEE-SCHEDULE SERVICES.—Actual
25 expenditures shall only take into ac-

1 count expenditures for services fur-
2 nished under the physician fee sched-
3 ule.

4 “(III) APPLICATION OF CAT-
5 EGORY SPECIFIC TARGET GROWTH
6 RATE.—The growth rate applied
7 under clause (ii)(II) of such para-
8 graph shall be the target growth rate
9 for the service category involved under
10 subsection (f)(5).

11 “(IV) ALLOCATION OF CUMU-
12 LATIVE OVERHANG.—There shall be
13 substituted for the difference de-
14 scribed in subparagraph (B)(ii)(I) of
15 such paragraph the amount described
16 in subparagraph (C)(i) for the service
17 category involved.

18 “(B) DETERMINATION OF ALLOWED EX-
19 PENDITURES.—In applying paragraph (4) for a
20 year beginning with 2008, notwithstanding sub-
21 paragraph (C)(iii) of such paragraph, the al-
22 lowed expenditures for a service category for a
23 year is an amount computed by the Secretary
24 as follows:

25 “(i) FOR 2008.—For 2008:

1 “(I) TOTAL 2007 ALLOWED EX-
2 PENDITURES.—Compute the total al-
3 lowed expenditures for services fur-
4 nished under the physician fee sched-
5 ule under such paragraph for 2007.

6 “(II) INCREASE BY GROWTH
7 RATE.—Increase the total under sub-
8 clause (I) by the target growth rate
9 for such category under subsection (f)
10 for 2008.

11 “(III) ALLOCATION TO SERVICE
12 CATEGORY.—Multiply the increased
13 total under subclause (II) by the over-
14 hang allocation factor for the service
15 category (as defined in subparagraph
16 (C)(iii)).

17 “(ii) FOR SUBSEQUENT YEARS.—For
18 a subsequent year, take the amount of al-
19 lowed expenditures for such category for
20 the preceding year (under clause (i) or this
21 clause) and increase it by the target
22 growth rate determined under subsection
23 (f) for such category and year.

1 “(C) COMPUTATION AND APPLICATION OF
2 CUMULATIVE OVERHANG AMONG CAT-
3 EGORIES.—

4 “(i) IN GENERAL.—For purposes of
5 applying paragraph (4)(B)(ii)(II) under
6 clause (ii)(IV), the amount described in
7 this clause for a year (beginning with
8 2008) is the sum of the following:

9 “(I) PRE-2008 CUMULATIVE
10 OVERHANG.—The amount of the pre-
11 2008 cumulative excess spending (as
12 defined in clause (ii)) multiplied by
13 the overhang allocation factor for the
14 service category (under clause (iii)).

15 “(II) POST-2007 CUMULATIVE
16 AMOUNTS.—For a year beginning
17 with 2009, the difference (which may
18 be positive or negative) between the
19 amount of the allowed expenditures
20 for physicians’ services (as determined
21 under paragraph (4)(C)) in the serv-
22 ice category from January 1, 2008,
23 through the end of the prior year and
24 the amount of the actual expenditures

1 for such services in such category dur-
2 ing that period.

3 “(ii) PRE-2008 CUMULATIVE EXCESS
4 SPENDING DEFINED.—For purposes of
5 clause (i)(I), the term ‘pre-2008 cumu-
6 lative excess spending’ means the dif-
7 ference described in paragraph
8 (4)(B)(ii)(I) as determined for the year
9 2008, taking into account expenditures
10 through December 31, 2007. Such dif-
11 ference takes into account expenditures in-
12 cluded in subsection (f)(4)(A).

13 “(iii) OVERHANG ALLOCATION FAC-
14 TOR.—For purposes of this paragraph, the
15 term ‘overhang allocation factor’ means,
16 for a service category, the proportion, as
17 determined by the Secretary of total actual
18 expenditures under this part for items and
19 services in such category during 2007 to
20 the total of such actual expenditures for all
21 the service categories. In calculating such
22 proportion, the Secretary shall only take
23 into account services furnished under the
24 physician fee schedule.

1 “(D) FLOOR FOR UPDATES FOR 2008 AND
2 2009.—The update to the conversion factors for
3 each service category for each of 2008 and
4 2009 shall be not less than 0.5 percent.

5 “(E) CHANGE IN RESTRICTION ON UPDATE
6 ADJUSTMENT FACTOR FOR 2010 AND 2011.—The
7 update adjustment factor determined under
8 subparagraph (4)(B), as modified by this para-
9 graph, for a service category for a year (begin-
10 ning with 2010 and ending with 2011) may be
11 less than -0.07, but may not be less than
12 -0.14.”.

13 (d) APPLICATION OF SEPARATE TARGET GROWTH
14 RATES FOR EACH CATEGORY.—

15 (1) IN GENERAL.—Section 1848(f) of the Social
16 Security Act (42 U.S.C. 1395w-4(f)) is amended by
17 adding at the end the following new paragraph:

18 “(5) APPLICATION OF SEPARATE TARGET
19 GROWTH RATES FOR EACH SERVICE CATEGORY BE-
20 GINNING WITH 2008.—The target growth rate for a
21 year beginning with 2008 shall be computed and ap-
22 plied separately under this subsection for each serv-
23 ice category (as defined in subsection (j)(5)) and
24 shall be computed using the same method for com-

puting the sustainable growth rate except for the following:

“(A) The reference in paragraphs (2)(A) and (2)(D) to ‘all physicians’ services’ is deemed a reference to the physicians’ services included in such category but shall not take into account items and services included in physicians’ services through the operation of paragraph (4)(A).

“(B) The factor described in paragraph (2)(C) for the service category described in subsection (j)(5)(A) shall be increased by 0.03.

“(C) A national coverage determination (as defined in section 1869(f)(1)(B)) shall be treated as a change in regulation described in paragraph (2)(D).”.

(2) USE OF TARGET GROWTH RATES.—Section 1848 of such Act is further amended—

(A) in subsection (d)—

(i) in paragraph (1)(E)(ii), by inserting “or target” after “sustainable”; and

(ii) in paragraph (4)(B)(ii)(II), by inserting “or target” after “sustainable”; and

(B) in subsection (f)—

1 (i) in the heading by inserting “; TAR-
2 GET GROWTH RATE” after “SUSTAINABLE
3 GROWTH RATE”

4 (ii) in paragraph (1)—

5 (I) by striking “and” at the end
6 of subparagraph (A);

7 (II) in subparagraph (B), by in-
8 serting “before 2008” after “each
9 succeeding year” and by striking the
10 period at the end and inserting “;
11 and”; and

12 (III) by adding at the end the
13 following new subparagraph:

14 “(C) November 1 of each succeeding year
15 the target growth rate for such succeeding year
16 and each of the 2 preceding years.”; and

17 (iii) in paragraph (2), in the matter
18 before subparagraph (A), by inserting after
19 “beginning with 2000” the following: “and
20 ending with 2007” .

21 (e) REPORTS ON EXPENDITURES FOR PART B
22 DRUGS AND CLINICAL DIAGNOSTIC LABORATORY
23 TESTS.—

24 (1) REPORTING REQUIREMENT.—The Secretary
25 of Health and Human Services shall include infor-

mation in the annual physician fee schedule proposed rule on the change in the annual rate of growth of actual expenditures for clinical diagnostic laboratory tests or drugs, biologicals, and radio-pharmaceuticals for which payment is made under part B of title XVIII of the Social Security Act.

(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall include an analysis of the reasons for such excess expenditures and recommendations for addressing them in the future.

**SEC. 302. IMPROVING ACCURACY OF RELATIVE VALUES
UNDER THE MEDICARE PHYSICIAN FEE
SCHEDULE.**

(a) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w(c)) is amended by adding at the end the following new paragraph:

“(7) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—

“(A) IN GENERAL.—The Secretary shall establish an expert panel (in this paragraph referred to as the ‘expert panel’)—

“(i) to identify, through data analysis, physicians' services for which the relative value under this subsection is potentially

1 misvalued, particularly those services for
2 which such relative value may be over-
3 valued;

4 “(ii) to assess whether those
5 misvalued services warrant review using
6 existing processes (referred to in para-
7 graph (2)(J)(ii)) for the consideration of
8 coding changes; and

9 “(iii) to advise the Secretary con-
10 cerning the exercise of authority under
11 clauses (ii)(III) and (vi) of paragraph
12 (2)(B).

13 “(B) COMPOSITION OF PANEL.—The ex-
14 pert panel shall be appointed by the Secretary
15 and composed of—

16 “(i) members with expertise in med-
17 ical economics and technology diffusion;

18 “(ii) members with clinical expertise;

19 “(iii) physicians, particularly physi-
20 cians (such as a physician employed by the
21 Veterans Administration or a physician
22 who has a full time faculty appointment at
23 a medical school) who are not directly af-
24 fected by changes in the physician fee
25 schedule under this section;

1 “(iv) carrier medical directors; and

2 “(v) representatives of private payor
3 health plans.

4 “(C) APPOINTMENT CONSIDERATIONS.—In
5 appointing members to the expert panel, the
6 Secretary shall assure racial and ethnic diver-
7 sity on the panel and may consider appointing
8 a liaison from organizations with experience in
9 the consideration of coding changes to the
10 panel.”.

11 (b) EXAMINATION OF SERVICES WITH SUBSTANTIAL
12 CHANGES.—Such section is further amended by adding at
13 the end the following new paragraph:

14 “(8) EXAMINATION OF SERVICES WITH SUB-
15 STANTIAL CHANGES.—The Secretary, in consultation
16 with the expert panel under paragraph (7), shall—

17 “(A) conduct a five-year review of physi-
18 cians’ services in conjunction with the RUC 5-
19 year review, particularly for services that have
20 experienced substantial changes in length of
21 stay, site of service, volume, practice expense,
22 or other factors that may indicate changes in
23 physician work;

24 “(B) identify new services to determine if
25 they are likely to experience a reduction in rel-

1 ative value over time and forward a list of the
2 services so identified for such five-year review;
3 and

4 “(C) for physicians’ services that are oth-
5 erwise unreviewed under the process the Sec-
6 retary has established, periodically review a
7 sample of relative value units within different
8 types of services to assess the accuracy of the
9 relative values contained in the Medicare physi-
10 cian fee schedule.”.

11 (c) AUTHORITY TO REDUCE WORK COMPONENT FOR
12 SERVICES WITH ACCELERATED VOLUME GROWTH.—

13 (1) IN GENERAL.—Paragraph (2)(B) of such
14 section is amended—

15 (A) in clause (v), by adding at the end the
16 following new subclause:

17 “(III) REDUCTIONS IN WORK
18 VALUE UNITS FOR SERVICES WITH AC-
19 CELERATED VOLUME GROWTH.—Ef-
20 fective January 1, 2009, reduced ex-
21 penditures attributable to clause
22 (vi).”; and

23 (B) by adding at the end the following new
24 clauses:

1 “(vi) AUTHORIZING REDUCTION IN
2 WORK VALUE UNITS FOR SERVICES WITH
3 ACCELERATED VOLUME GROWTH.—The
4 Secretary may provide (without using ex-
5 isting processes the Secretary has estab-
6 lished for review of relative value) for a re-
7 duction in the work value units for a par-
8 ticular physician’s service if the annual
9 rate of growth in the expenditures for such
10 service for which payment is made under
11 this part for individuals for 2006 or a sub-
12 sequent year exceeds the average annual
13 rate of growth in expenditures of all physi-
14 cians’ services for which payment is made
15 under this part by more than 10 percent-
16 age points for such year.

17 “(vii) CONSULTATION WITH EXPERT
18 PANEL AND BASED ON CLINICAL EVI-
19 DENCE.—The Secretary shall exercise au-
20 thority under clauses (ii)(III) and (vi) in
21 consultation with the expert panel estab-
22 lished under paragraph (7) and shall take
23 into account clinical evidence supporting or
24 refuting the merits of such accelerated
25 growth”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by paragraph (1) shall apply with respect to pay-
3 ment for services furnished on or after January 1,
4 2009.

5 (d) ADJUSTMENT AUTHORITY FOR EFFICIENCY
6 GAINS FOR NEW PROCEDURES.—Paragraph (2)(B)(ii) of
7 such section is amended by adding at the end the following
8 new subclause:

9 “(III) ADJUSTMENT AUTHORITY
10 FOR EFFICIENCY GAINS FOR NEW
11 PROCEDURES.—In carrying out sub-
12 clauses (I) and (II), the Secretary
13 may apply a methodology, based on
14 supporting evidence, under which
15 there is imposed a reduction over a
16 period of years in specified relative
17 value units in the case of a new (or
18 newer) procedure to take into account
19 inherent efficiencies that are typically
20 or likely to be gained during the pe-
21 riod of initial increased application of
22 the procedure.”.

1 **SEC. 303. PHYSICIAN FEEDBACK MECHANISM ON PRACTICE**
2 **PATTERNS.**

3 By not later than July 1, 2008, the Secretary of
4 Health and Human Services shall develop and implement
5 a mechanism to measure resource use on a per capita and
6 an episode basis in order to provide confidential feedback
7 to physicians in the Medicare program on how their prac-
8 tice patterns compare to physicians generally, both in the
9 same locality as well as nationally. Such feedback shall
10 not be subject to disclosure under section 552 of title 5,
11 United States Code).

12 **SEC. 304. PAYMENTS FOR EFFICIENT PHYSICIANS.**

13 Section 1833 of the Social Security Act (42 U.S.C.
14 1395l) is amended by adding at the end the following new
15 subsection:

16 “(v) INCENTIVE PAYMENTS FOR EFFICIENT PHYSI-
17 CIANS.—

18 “(1) IN GENERAL.—In the case of physicians’
19 services furnished on or after January 1, 2009, and
20 before January 1, 2011, by a participating physician
21 in an efficient area (as identified under paragraph
22 (2)), in addition to the amount of payment that
23 would otherwise be made for such services under this
24 part, there also shall be paid an amount equal to 5
25 percent of the payment amount for the services
26 under this part.

1 “(2) IDENTIFICATION OF EFFICIENT AREAS.—

2 “(A) IN GENERAL.—Based upon available
3 data, the Secretary shall identify those counties
4 or equivalent areas in the United States in the
5 lowest fifth percentile of utilization based on
6 per capita spending for services provided in
7 2007 under this part and part A.

8 “(B) IDENTIFICATION OF COUNTIES
9 WHERE SERVICE IS FURNISHED.—For pur-
10 poses of paying the additional amount specified
11 in paragraph (1), if the Secretary uses the 5-
12 digit postal ZIP Code where the service is fur-
13 nished, the dominant county of the postal ZIP
14 Code (as determined by the United States Post-
15 al Service, or otherwise) shall be used to deter-
16 mine whether the postal ZIP Code is in a coun-
17 ty described in subparagraph (A).

18 “(C) JUDICIAL REVIEW.— There shall be
19 no administrative or judicial review under sec-
20 tion 1869, 1878, or otherwise, respecting—

21 “(i) the identification of a county or
22 other area under subparagraph (A); or

23 “(ii) the assignment of a postal ZIP
24 Code to a county or other area under sub-
25 paragraph (B).

1 “(D) PUBLICATION OF LIST OF COUNTIES;
2 POSTING ON WEBSITE.—With respect to a year
3 for which a county or area is identified under
4 this paragraph, the Secretary shall identify
5 such counties or areas as part of the proposed
6 and final rule to implement the physician fee
7 schedule under section 1848 for the applicable
8 year. The Secretary shall post the list of coun-
9 ties identified under this paragraph on the
10 Internet website of the Centers for Medicare
11 & Medicaid Services.”.

12 **SEC. 305. RECOMMENDATIONS ON REFINING THE PHYSI-**
13 **CIAN FEE SCHEDULE.**

14 (a) RECOMMENDATIONS ON CONSOLIDATED CODING
15 FOR SERVICES COMMONLY PERFORMED TOGETHER.—
16 Not later than December 31, 2008, the Comptroller Gen-
17 eral of the United States shall—

18 (1) complete an analysis of codes paid under
19 the Medicare physician fee schedule to determine
20 whether the codes for procedures that are commonly
21 furnished together should be combined; and

22 (2) submit to Congress a report on such anal-
23 ysis and include in the report recommendations on
24 whether an adjustment should be made to the rel-
25 ative value units for such combined code.

(b) RECOMMENDATIONS ON INCREASED USE OF BUNDLED PAYMENTS.—Not later than December 31, 2008, the Comptroller General of the United States shall—

(1) complete an analysis of those procedures under the Medicare physician fee schedule for which no global payment methodology is applied but for which a “bundled” payment methodology would be appropriate; and

(2) submit to Congress a report on such analysis and include in the report recommendations on increasing the use of “bundled” payment methodology under such schedule.

(c) MEDICARE PHYSICIAN FEE SCHEDULE.—In this section, the term “Medicare physician fee schedule” means the fee schedule established under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

SEC. 306. IMPROVED AND EXPANDED MEDICAL HOME DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish under title XVIII of the Social Security Act an expanded medical home demonstration project (in this section referred to as the “expanded project”) under this section. The expanded project super-

1 sedes the project that was initiated under section 204 of
2 the Medicare Improvement and Extension Act of 2006 (di-
3 vision B of Public Law 109-432). The purpose of the ex-
4 panded project is—

5 (1) to guide the redesign of the health care de-
6 livery system to provide accessible, continuous, com-
7 prehensive, and coordinated, care to Medicare bene-
8 ficiaries; and

9 (2) to provide care management fees to per-
10 sonal physicians delivering continuous and com-
11 prehensive care in qualified medical homes.

12 (b) NATURE AND SCOPE OF PROJECT.—

13 (1) DURATION; SCOPE.—The expanded project
14 shall operate during a period of three years, begin-
15 ning not later than October 1, 2009, and shall in-
16 clude a nationally representative sample of physi-
17 cians serving urban, rural, and underserved areas
18 throughout the United States.

19 (2) ENCOURAGING PARTICIPATION OF SMALL
20 PHYSICIAN PRACTICES.—

21 (A) IN GENERAL.—The expanded project
22 shall be designed to include the participation of
23 physicians in practices with fewer than four
24 full-time equivalent physicians, as well as physi-

1 cians in larger practices particularly in rural
2 and underserved areas.

3 (B) TECHNICAL ASSISTANCE.— In order to
4 facilitate the participation under the expanded
5 project of physicians in such practices, the Sec-
6 retary shall make available additional technical
7 assistance to such practices during the first
8 year of the expanded project.

9 (3) SELECTION OF HOMES TO PARTICIPATE.—
10 The Secretary shall select up to 500 medical homes
11 to participate in the expanded project and shall give
12 priority to—

13 (A) the selection of up to 100 HIT-en-
14 hanced medical homes; and

15 (B) the selection of other medical homes
16 that serve communities whose populations are
17 at higher risk for health disparities,

18 (4) BENEFICIARY PARTICIPATION.—The Sec-
19 retary shall establish a process for any Medicare
20 beneficiary who is served by a medical home partici-
21 pating in the expanded project to elect to participate
22 in the project. Each beneficiary who elects to so partici-
23 pate shall be eligible—

1 (A) for enhanced medical home services
2 under the project with no cost sharing for the
3 additional services; and

4 (B) for a reduction of up to 50 percent in
5 the coinsurance for services furnished under the
6 physician fee schedule under section 1848 of
7 the Social Security Act by the medical home.

8 The Secretary shall develop standard recruitment
9 materials and election processes for Medicare bene-
10 ficiaries who are electing to participate in the ex-
11 panded project.

12 (c) STANDARDS FOR MEDICAL HOMES, HIT-EN-
13 HANCED MEDICAL HOMES.—

14 (1) STANDARD SETTING AND CERTIFICATION
15 PROCESS.—The Secretary shall establish a process
16 for selection of a qualified standard setting and cer-
17 tification organization—

18 (A) to establish standards, consistent with
19 this section, for medical practices to qualify as
20 medical homes or as HIT-enhanced medical
21 homes; and

22 (B) to provide for the review and certifi-
23 cation of medical practices as meeting such
24 standards.

1 (2) BASIC STANDARDS FOR MEDICAL HOMES.—

2 For purposes of this subsection, the term “medical
3 home” means a physician-directed practice that has
4 been certified, under paragraph (1), as meeting the
5 following standards:

6 (A) ACCESS AND COMMUNICATION WITH
7 PATIENTS.—The practice applies standards for
8 access to care and communication with partici-
9 pating beneficiaries.

10 (B) MANAGING PATIENT INFORMATION
11 AND USING INFORMATION IN MANAGEMENT TO
12 SUPPORT PATIENT CARE.—The practice has
13 readily accessible, clinically useful information
14 on participating beneficiaries that enables the
15 practice to treat such beneficiaries comprehen-
16 sively and systematically.

17 (C) MANAGING AND COORDINATING CARE
18 ACCORDING TO INDIVIDUAL NEEDS.—The prac-
19 tice maintains continuous relationships with
20 participating beneficiaries by implementing evi-
21 dence-based guidelines and applying them to
22 the identified needs of individual beneficiaries
23 over time and with the intensity needed by such
24 beneficiaries.

1 (D) PROVIDING ONGOING ASSISTANCE AND
2 ENCOURAGEMENT IN PATIENT SELF-MANAGE-
3 MENT.—The practice—

4 (i) collaborates with participating
5 beneficiaries to pursue their goals for opti-
6 mal achievable health; and

7 (ii) assesses patient-specific barriers
8 to communication and conducts activities
9 to support patient self-management.

10 (E) RESOURCES TO MANAGE CARE.—The
11 practice has in place the resources and pro-
12 cesses necessary to achieve improvements in the
13 management and coordination of care for par-
14 ticipating beneficiaries.

15 (F) MONITORING PERFORMANCE.—The
16 practice monitors its clinical process and per-
17 formance (including outcome measures) in
18 meeting the applicable standards under this
19 subsection and provides information in a form
20 and manner specified by the Secretary with re-
21 spect to such process and performance.

22 (3) ADDITIONAL STANDARDS FOR HIT-EN-
23 HANCED MEDICAL HOME.—For purposes of this sub-
24 section, the term “HIT-enhanced medical home”
25 means a medical home that has been certified, under

1 paragraph (1), as using a health information tech-
2 nology system that includes at least the following
3 elements:

4 (A) ELECTRONIC HEALTH RECORD
5 (EHR).—The system uses, for participating
6 beneficiaries, an electronic health record that
7 meets the following standards:

8 (i) IN GENERAL.—The record—

9 (I) has the capability of inter-
10 operability with secure data acquisi-
11 tion from health information tech-
12 nology systems of other health care
13 providers in the area served by the
14 home; or

15 (II) the capability to securely ac-
16 quire clinical data delivered by such
17 other health care providers to a secure
18 common data source.

19 (ii) The record protects the privacy
20 and security of health information.

21 (iii) The record has the capability to
22 acquire, manage, and display all the types
23 of clinical information commonly relevant
24 to services furnished by the home, such as
25 complete medical records, radiographic

1 image retrieval, and clinical laboratory in-
2 formation.

3 (iv) The record is integrated with de-
4 cision support capacities that facilitate the
5 use of evidence-based medicine and clinical
6 decision support tools to guide decision-
7 making at the point-of-care based on pa-
8 tient-specific factors.

9 (B) E-PRESCRIBING.—The system sup-
10 ports e-prescribing and computerized physician
11 order entry.

12 (C) OUTCOME MEASUREMENT.—The sys-
13 tem supports the secure, confidential provision
14 of clinical process and outcome measures ap-
15 proved by the National Quality Forum to the
16 Secretary for use in confidential manner for
17 provider feedback and peer review and for out-
18 comes and clinical effectiveness research.

19 (D) PATIENT EDUCATION CAPABILITY.—
20 The system actively facilitates participating
21 beneficiaries engaging in the management of
22 their own health through education and support
23 systems and tools for shared decision-making.

24 (E) SUPPORT OF BASIC STANDARDS.—
25 The elements of such system, such as the elec-

1 tronic health record, email communications, pa-
2 tient registries, and clinical-decision support
3 tools, are integrated in a manner to better
4 achieve the basic standards specified in para-
5 graph (2) for a medical home.

6 (4) USE OF DATA.—The Secretary shall use the
7 data submitted under paragraph (1)(F) in a con-
8 fidential manner for feedback and peer review for
9 medical homes and for outcomes and clinical effec-
10 tiveness research. After the first two years of the ex-
11 panded project, these data may be used for adjust-
12 ment in the monthly medical home care management
13 fee under subsection (d)(2)(E).

14 (d) MONTHLY MEDICAL HOME CARE MANAGEMENT
15 FEE.—

16 (1) IN GENERAL.—Under the expanded project,
17 the Secretary shall provide for payment to the per-
18 sonal physician of each participating beneficiary of a
19 monthly medical home care management fee.

20 (2) AMOUNT OF PAYMENT.— In determining
21 the amount of such fee, the Secretary shall consider
22 the following:

23 (A) OPERATING EXPENSES.—The addi-
24 tional practice expenses for the delivery of serv-
25 ices through a medical home, taking into ac-

1 count the additional expenses for an HIT-en-
2 hanced medical home. Such expenses include
3 costs associated with—

4 (i) structural expenses, such as equip-
5 ment, maintenance, and training costs;

6 (ii) enhanced access and communica-
7 tion functions;

8 (iii) population management and reg-
9 istry functions;

10 (iv) patient medical data and referral
11 tracking functions;

12 (v) provision of evidence-based care;

13 (vi) implementation and maintenance
14 of health information technology;

15 (vii) reporting on performance and
16 improvement conditions; and

17 (viii) patient education and patient
18 decision support, including print and elec-
19 tronic patient education materials.

20 (B) ADDED VALUE SERVICES.—The value
21 of additional physician work, such as aug-
22 mented care plan oversight, expanded e-mail
23 and telephonic consultations, extended patient
24 medical data review (including data stored and
25 transmitted electronically), and physician super-

1 vision of enhanced self management education,
2 and expanded follow-up accomplished by non-
3 physician personnel, in a medical home that is
4 not adequately taken into account in the estab-
5 lishment of the physician fee schedule under
6 section 1848 of the Social Security Act.

7 (C) RISK ADJUSTMENT.—The development
8 of an appropriate risk adjustment mechanism
9 to account for the varying costs of medical
10 homes based upon characteristics of partici-
11 pating beneficiaries.

12 (D) HIT ADJUSTMENT.—Variation of the
13 fee based on the extensiveness of use of the
14 health information technology in the medical
15 home.

16 (E) PERFORMANCE-BASED.—After the
17 first two years of the expanded project, an ad-
18 justment of the fee based on performance of the
19 home in achieving quality or outcomes stand-
20 ards.

21 (3) PERSONAL PHYSICIAN DEFINED.—For pur-
22 poses of this subsection, the term “personal physi-
23 cian” means, with respect to a participating Medi-
24 care beneficiary, a physician (as defined in section
25 1861(r)(1) of the Social Security Act (42 U.S.C.

1 1395x(r)(1)) who provides accessible, continuous, co-
2 ordinated, and comprehensive care for the bene-
3 ficiary as part of a medical practice that is a quali-
4 fied medical home. Such a physician may be a spe-
5 cialist for a beneficiary requiring ongoing care for a
6 chronic condition or multiple chronic conditions
7 (such as severe asthma, complex diabetes, cardio-
8 vascular disease, rheumatologic disorder) or for a
9 beneficiary with a prolonged illness.

10 (e) FUNDING.—

11 (1) USE OF CURRENT PROJECT FUNDING.—

12 Funds otherwise applied to the demonstration under
13 section 204 of the Medicare Improvement and Ex-
14 tension Act of 2006 (division B of Public Law 109–
15 432) shall be available to carry out the expanded
16 project

17 (2) ADDITIONAL FUNDING FROM SMI TRUST

18 FUND.—

19 (A) IN GENERAL.—In addition to the

20 funds provided under paragraph (1), there shall
21 be available, from the Federal Supplementary
22 Medical Insurance Trust Fund (under section
23 1841 of the Social Security Act), the amount of
24 \$500,000,000 to carry out the expanded
25 project, including payments to of monthly med-

1 ical home care management fees under sub-
2 section (d), reductions in coinsurance for par-
3 ticipating beneficiaries under subsection
4 (b)(4)(B), and funds for the design, implemen-
5 tation, and evaluation of the expanded project.

6 (B) MONITORING EXPENDITURES; EARLY
7 TERMINATION.—The Secretary shall monitor
8 the expenditures under the expanded project
9 and may terminate the project early in order
10 that expenditures not exceed the amount of
11 funding provided for the project under subpara-
12 graph (A).

13 (f) EVALUATIONS AND REPORTS.—

14 (1) ANNUAL INTERIM EVALUATIONS AND RE-
15 PORTS.—For each year of the expanded project, the
16 Secretary shall provide for an evaluation of the
17 project and shall submit to Congress, by a date spec-
18 ified by the Secretary, a report on the project and
19 on the evaluation of the project for each such year.

20 (2) FINAL EVALUATION AND REPORT.—The
21 Secretary shall provide for an evaluation of the ex-
22 panded project and shall submit to Congress, not
23 later than 18 months after the date of completion of
24 the project, a report on the project and on the eval-
25 uation of the project.

1 **SEC. 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUAL-**
2 **ITY INITIATIVE FUND.**

3 Subsection (l) of section 1848 of the Social Security
4 Act (42 U.S.C. 1395w-4) is repealed.

5 **SEC. 308. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-**
6 **ITIES.**

7 Section 1848(e) of the Social Security Act (42
8 U.S.C.1395w-4(e)) is amended by adding at the end the
9 following new paragraph:

10 “(6) FEE SCHEDULE GEOGRAPHIC AREAS.—

11 “(A) IN GENERAL.—

12 “(i) REVISION.—Subject to clause (ii),
13 for services furnished on or after January
14 1, 2009, the Secretary shall revise the fee
15 schedule areas used for payment under
16 this section applicable to the State of Cali-
17 fornia using the county-based geographic
18 adjustment factor as specified in option 3
19 (table 9) in the proposed rule for the 2008
20 physician fee schedule published at 72
21 Fed. Reg. 38,122 (July 12, 2007).

22 “(ii) TRANSITION.—For services fur-
23 nished during the period beginning Janu-
24 ary 1, 2009, and ending December 31,
25 2010, after calculating the work, practice
26 expense, and malpractice geographic indi-

ces described in clauses (i), (ii), and (iii) of paragraph (1)(A) that would otherwise apply, the Secretary shall increase any such geographic index for any county in California that is lower than the geographic index used for payment for services under this section as of December 31, 2008, in such county to such geographic index level.

“(iii) NON-APPLICATION OF PERIODIC REVISION.—If a periodic review of geographic indices, as required under paragraph (1)(B), results in a reduction in a work, practice expense and malpractice geographic index for any county in California that is below the geographic index level established pursuant to clause (ii) during a portion of the period described in such clause, the work, practice expense, or malpractice index established in such clause shall be applied to payment for services furnished in such county during such portion of such period.

“(B) SUBSEQUENT REVISIONS.—

1 “(i) TIMING.—Not later than January
2 1, 2014, the Secretary shall review and
3 make revisions to fee schedule areas in all
4 States for which more than one fee sched-
5 ule area is used for payment of services
6 under this section. The Secretary may re-
7 vise fee schedule areas in States in which
8 a single fee schedule area is used for pay-
9 ment for services under this section using
10 the same methodology applied in the pre-
11 vious sentence.

12 “(ii) LINK WITH GEOGRAPHIC INDEX
13 DATA REVISION.—The revision described in
14 clause (i) shall be made effective concu-
15 rently with the application of the periodic
16 review of geographic adjustment factors re-
17 quired under paragraph (1)(C) for 2014.”.

18 **SEC. 309. PAYMENT FOR IMAGING SERVICES.**

19 (a) PAYMENT UNDER PART B OF THE MEDICARE
20 PROGRAM FOR DIAGNOSTIC IMAGING SERVICES FUR-
21 NISHED IN FACILITIES CONDITIONED ON ACCREDITATION
22 OF FACILITIES.—

23 (1) SPECIAL PAYMENT RULE.—

1 (A) IN GENERAL.—Section 1848(b)(4) of
2 the Social Security Act (42 U.S.C. 1395w-
3 4(b)(4)) is amended—

4 (i) in the heading, by striking “RULE”
5 and inserting “RULES”;

6 (ii) in subparagraph (A), by striking
7 “IN GENERAL” and inserting “LIMITA-
8 TION”; and

9 (iii) by adding at the end the fol-
10 lowing new subparagraph:

11 “(C) PAYMENT ONLY FOR SERVICES PRO-
12 VIDED IN ACCREDITED FACILITIES.—

13 “(i) IN GENERAL.—In the case of im-
14 aging services that are diagnostic imaging
15 services described in clause (ii), the pay-
16 ment amount for the technical component
17 and the professional component of the
18 services established for a year under the
19 fee schedule described in paragraph (1)
20 shall each be zero, unless the services are
21 furnished at a diagnostic imaging services
22 facility that meets the certificate require-
23 ment described in section 354(b)(1) of the
24 Public Health Service Act, as applied
25 under subsection (m). The previous sen-

tence shall not apply with respect to the professional component of a diagnostic imaging service that is furnished by a physician or that is an ultrasound furnished by nurse practitioner or or nurse-midwife.

“(ii) DIAGNOSTIC IMAGING SERVICES.—For purposes of clause (i) and subsection (m), the term ‘diagnostic imaging services’ means all imaging modalities, including diagnostic magnetic resonance imaging (‘MRI’), computed tomography (‘CT’), positron emission tomography (‘PET’), nuclear medicine procedures, x-rays, sonograms, ultrasounds, echocardiograms, and such emerging diagnostic imaging technologies as specified by the Secretary. Such term does not include image guided procedures.”.

(B) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) shall apply to diagnostic imaging services furnished on or after January 1, 2010.

1 (ii) EXTENSION FOR ULTRASOUND
2 SERVICES.—The amendments made by
3 subparagraph (A) shall apply to diagnostic
4 imaging services that are ultrasound serv-
5 ices on or after January 1, 2012.

6 (2) CERTIFICATION OF FACILITIES THAT FUR-
7 NISH DIAGNOSTIC IMAGING SERVICES.—Section
8 1848 of the Social Security Act (42 U.S.C. 1395w-
9 4) is amended by adding at the end the following
10 new subsection:

11 “(m) CERTIFICATION OF FACILITIES THAT FURNISH
12 DIAGNOSTIC IMAGING SERVICES.—

13 “(1) IN GENERAL.—For purposes of subsection
14 (b)(4)(C)(i), except as provided under paragraphs
15 (2) through (8), the provisions of section 354 of the
16 Public Health Service Act (as in effect as of June
17 1, 2007), relating to the certification of mammog-
18 raphy facilities, shall apply, with respect to the pro-
19 vision of diagnostic imaging services (as defined in
20 subsection (b)(4)(C)(ii)) and to a diagnostic imaging
21 services facility defined in paragraph (8) (and to the
22 process of accrediting such facilities) in the same
23 manner that such provisions apply, with respect to
24 the provision of mammograms and to a facility de-

1 fined in subsection (a)(3) of such section (and to the
2 process of accrediting such mammography facilities).

3 “(2) TERMINOLOGY AND REFERENCES.—For
4 purposes of applying section 354 of the Public
5 Health Service Act under paragraph (1)—

6 “(A) any reference to ‘mammography’, or
7 ‘breast imaging’ is deemed a reference to ‘diag-
8 nostic imaging services (as defined in section
9 1848(b)(4)(C)(ii) of the Social Security Act)’;

10 “(B) any reference to a mammogram or
11 film is deemed a reference to an image, as de-
12 fined in paragraph (8);

13 “(C) any reference to ‘mammography facil-
14 ity’ or to a ‘facility’ under such section 354 is
15 deemed a reference to a diagnostic imaging
16 services facility, as defined in paragraph (8);

17 “(D) any reference to radiological equip-
18 ment used to image the breast is deemed a ref-
19 erence to medical imaging equipment used to
20 provide diagnostic imaging services;

21 “(E) any reference to radiological proce-
22 dures or radiological is deemed a reference to
23 medical imaging services, as defined in para-
24 graph (8) or medical imaging, respectively;

1 “(F) any reference to an inspection (as de-
2 fined in subsection (a)(4) of such section) or in-
3 spector is deemed a reference to an audit (as
4 defined in paragraph (8)) or auditor, respec-
5 tively;

6 “(G) any reference to a medical physicist
7 (as described in subsection (f)(1)(E) of such
8 section) is deemed to include a reference to a
9 magnetic resonance scientist or the appropriate
10 qualified expert as determined by the accred-
11 iting body;

12 “(H) in applying subsection (d)(1)(A)(i) of
13 such section, the reference to ‘type of each x-
14 ray machine, image receptor, and processor’ is
15 deemed a reference to ‘type of imaging equip-
16 ment’;

17 “(I) in applying subsection (d)(1)(B) of
18 such section, the reference that ‘the person or
19 agent submits to the Secretary’ is deemed a ref-
20 erence that ‘the person or agent submits to the
21 Secretary, through the appropriate accredita-
22 tion body’;

23 “(J) in applying subsection (d)(1)(B)(i) of
24 such section, the reference to standards estab-
25 lished by the Secretary is deemed a reference to

1 standards established by an accreditation body
2 and approved by the Secretary;

3 “(K) in applying subsection (e) of such
4 section, relating to an accreditation body—

5 “(i) in paragraph (1)(A), the ref-
6 erence to ‘may’ is deemed a reference to
7 ‘shall’;

8 “(ii) in paragraph (1)(B)(i)(II), the
9 reference to ‘a random sample of clinical
10 images from such facilities’ is deemed a
11 reference to ‘a statistically significant ran-
12 dom sample of clinical images from a sta-
13 tistically significant random sample of fa-
14 cilities’;

15 “(iii) in paragraph (3)(A) of such sec-
16 tion—

17 “(I) the reference to ‘paragraph
18 (1)(B)’ in such subsection is deemed
19 to be a reference to ‘paragraph (1)(B)
20 and subsection (f)’; and

21 “(II) the reference to the ‘Sec-
22 retary’ is deemed a reference to ‘an
23 accreditation body, with the approval
24 of the Secretary’; and

1 “(iv) in paragraph (6)(B), the ref-
2 erence to the Committee on Labor and
3 Human Resources of the Senate is deemed
4 to be the Committee on Finance of the
5 Senate and the reference to the Committee
6 on Energy and Commerce of the House of
7 Representatives is deemed to include a ref-
8 erence to the Committee on Ways and
9 Means of the House of Representatives;
10 “(L) in applying subsection (f), relating to
11 quality standards—

12 “(i) each reference to standards estab-
13 lished by the Secretary is deemed a ref-
14 erence to standards established by an ac-
15 creditation body involved and approved by
16 the Secretary under subsection (d)(1)(B)(i)
17 of such section

18 “(ii) in paragraph (1)(A), the ref-
19 erence to ‘radiation dose’ is deemed a ref-
20 erence to ‘radiation dose, as appropriate’;

21 “(iii) in paragraph (1)(B), the ref-
22 erence to ‘radiological standards’ is deemed
23 a reference to ‘medical imaging standards,
24 as appropriate’;

1 “(iv) in paragraphs (1)(D)(ii) and
2 (1)(E)(iii), the reference to ‘the Secretary’
3 is deemed a reference to ‘an accreditation
4 body with the approval of the Secretary’;

5 “(v) in each of subclauses (III) and
6 (IV) of paragraph (1)(G)(ii), each ref-
7 erence to ‘patient’ is deemed a reference to
8 ‘patient, if requested by the patient’; and
9 “(M) in applying subsection (g), relating to

10 inspections—

11 “(i) each reference to the ‘Secretary
12 or State or local agency acting on behalf of
13 the Secretary’ is deemed to include a ref-
14 erence to an accreditation body involved;

15 “(ii) in the first sentence of para-
16 graph (1)(F), the reference to ‘annual in-
17 spections required under this paragraph’ is
18 deemed a reference to ‘the audits carried
19 out in facilities at least every three years
20 from the date of initial accreditation under
21 this paragraph’; and

22 “(iii) in the second sentence of para-
23 graph (1)(F), the reference to ‘inspections
24 carried out under this paragraph’ is
25 deemed a reference to ‘audits conducted

1 under this paragraph during the previous
2 year’.

3 “(3) DATES AND PERIODS.—For purposes of
4 paragraph (1), in applying section 354 of the Public
5 Health Service Act, the following applies:

6 “(A) IN GENERAL.—Except as provided in
7 subparagraph (B)—

8 “(i) any reference to ‘October 1,
9 1994’ shall be deemed a reference to ‘Jan-
10 uary 1, 2010’;

11 “(ii) the reference to ‘the date of the
12 enactment of this section’ in each of sub-
13 sections (e)(1)(D) and (f)(1)(E)(iii) is
14 deemed to be a reference to ‘the date of
15 the enactment of the Children’s Health
16 and Medicare Protection Act of 2007’;

17 “(iii) the reference to ‘annually’ in
18 subsection (g)(1)(E) is deemed a reference
19 to ‘every three years’;

20 “(iv) the reference to ‘October 1,
21 1996’ in subsection (l) is deemed to be a
22 reference to ‘January 1, 2011’;

23 “(v) the reference to ‘October 1,
24 1999’ in subsection (n)(3)(H) is deemed to
25 be a reference to ‘January 1, 2012’; and

1 “(vi) the reference to ‘October 1,
2 1993’ in the matter following paragraph
3 (3)(J) of subsection (n) is deemed to be a
4 reference ‘January 1, 2010’.

5 “(B) ULTRASOUND SERVICES.—With re-
6 spect to diagnostic imaging services that are
7 ultrasounds—

8 “(i) any reference to ‘October 1,
9 1994’ shall be deemed a reference to ‘Jan-
10 uary 1, 2012’;

11 “(ii) the reference to ‘the date of the
12 enactment of this section’ in subsection
13 (f)(1)(E)(iii) is deemed to be a reference to
14 ‘7 years after the date of the enactment of
15 the Children’s Health and Medicare Pro-
16 tection Act of 2007’;

17 “(iii) the reference to ‘October 1,
18 1996’ in subsection (l) is deemed to be a
19 reference to ‘January 1, 2013’;

20 “(4) PROVISIONS NOT APPLICABLE.—For pur-
21 poses of paragraph (1), in applying section 354 of
22 the Public Health Service Act, the following provi-
23 sion shall not apply:

24 “(A) Subsections (e) and (f) of such sec-
25 tion, in so far as the respective subsection im-

1 poses any requirement for a physician to be cer-
2 tified, accredited, or otherwise meet require-
3 ments, with respect to the provision of any di-
4 agnostic imaging services, as a condition of pay-
5 ment under subsection (b)(4)(C)(i), with re-
6 spect to the professional or technical compo-
7 nent, for such service.

8 “(B) Subsection (e)(1)(B)(iv) of such sec-
9 tion, insofar as it applies to a facility with re-
10 spect to the provision of ultrasounds.

11 “(C) Subsection (e)(1)(B)(v).

12 “(D) Subsection (f)(1)(H) of such section,
13 relating to standards for special techniques for
14 mammograms of patients with breast implants.

15 “(E) Subsection (g)(6) of such section, re-
16 lating to an inspection demonstration program.

17 “(F) Subsection (n)(3)(G) of such section,
18 relating to the national advisory committee.

19 “(G) Subsection (p) of such section, relat-
20 ing to breast cancer screening surveillance re-
21 search grants.

22 “(H) Paragraphs (1)(B) and (2) of sub-
23 section (r) of such section, related to funding.

1 “(5) ACCREDITATION BODIES.—For purposes
2 of paragraph (1), in applying section 354(e)(1) of
3 the Public Health Service, the following shall apply:

4 “(A) APPROVAL OF TWO ACCREDITATION
5 BODIES FOR EACH TREATMENT MODALITY.—In
6 the case that there is more than one accredita-
7 tion body for a treatment modality that quali-
8 fies for approval under this subsection, the Sec-
9 retary shall approve at least two accreditation
10 bodies for such treatment modality.

11 “(B) ADDITIONAL ACCREDITATION BODY
12 STANDARDS.—In addition to the standards de-
13 scribed in subparagraph (B) of such section for
14 accreditation bodies, the Secretary shall estab-
15 lish standards that require—

16 “(i) the timely integration of new
17 technology by accreditation bodies for pur-
18 poses of accrediting facilities under this
19 subsection; and

20 “(ii) the accreditation body involved to
21 evaluate the annual medical physicist sur-
22 vey (or annual medical survey of another
23 appropriate qualified expert chosen by the
24 accreditation body) of a facility upon on-
25 site review of such facility.

1 “(6) ADDITIONAL QUALITY STANDARDS.—For
2 purposes of paragraph (1), in applying subsection
3 (f)(1) of section 354 of the Public Health Service—

4 “(A) the quality standards under such sub-
5 section shall, with respect to a facility include—

6 “(i) standards for qualifications of
7 medical personnel who are not physicians
8 and who perform diagnostic imaging serv-
9 ices at the facility that require such per-
10 sonnel to ensure that individuals, prior to
11 performing medical imaging, demonstrate
12 compliance with the standards established
13 under subsection (a) through successful
14 completion of certification by a nationally
15 recognized professional organization, licen-
16 sure, completion of an examination, perti-
17 nent coursework or degree program,
18 verified pertinent experience, or through
19 other ways determined appropriate by an
20 accreditation body (with the approval of
21 the Secretary, or through some combina-
22 tion thereof);

23 “(ii) standards requiring the facility
24 to maintain records of the credentials of

1 physicians and other medical personnel de-
2 scribed in clause (i);

3 “(iii) standards for qualifications and
4 responsibilities of medical directors and
5 other personnel with supervising roles at
6 the facility;

7 “(iv) standards that require the facil-
8 ity has procedures to ensure the safety of
9 patients of the facility; and

10 “(v) standards for the establishment
11 of a quality control program at the facility
12 to be implemented as described in subpara-
13 graph (E) of such subsection;

14 “(B) the quality standards described in
15 subparagraph (B) of such subsection shall be
16 deemed to include standards that require the
17 establishment and maintenance of a quality as-
18 surance and quality control program at each fa-
19 cility that is adequate and appropriate to en-
20 sure the reliability, clarity, and accuracy of the
21 technical quality of diagnostic images produced
22 at such facilities; and

23 “(C) the quality standard described in sub-
24 paragraph (C) of such subsection, relating to a
25 requirement for personnel who perform speci-

1 fied services, shall include in such requirement
2 that such personnel must meet continuing med-
3 ical education standards as specified by an ac-
4 creditation body (with the approval of the Sec-
5 retary) and update such standards at least once
6 every three years.

7 “(7) ADDITIONAL REQUIREMENTS.—Notwith-
8 standing any provision of section 354 of the Public
9 Health Service Act, the following shall apply to the
10 accreditation process under this subsection for pur-
11 poses of subsection (b)(4)(C)(i):

12 “(A) Any diagnostic imaging services facil-
13 ity accredited before January 1, 2010 (or Janu-
14 ary 1, 2012 in the case of ultrasounds), by an
15 accrediting body approved by the Secretary
16 shall be deemed a facility accredited by an ap-
17 proved accreditation body for purposes of such
18 subsection as of such date if the facility submits
19 to the Secretary proof of such accreditation by
20 transmittal of the certificate of accreditation,
21 including by electronic means.

22 “(B) The Secretary may require the ac-
23 creditation under this subsection of an emerg-
24 ing technology used in the provision of a diag-
25 nostic imaging service as a condition of pay-

1 ment under subsection (b)(4)(C)(i) for such
2 service at such time as the Secretary deter-
3 mines there is sufficient empirical and scientific
4 information to properly carry out the accredita-
5 tion process for such technology.

6 “(8) DEFINITIONS.—For purposes of this sub-
7 section:

8 “(A) AUDIT.—The term ‘audit’ means an
9 onsite evaluation, with respect to a diagnostic
10 imaging services facility, by the Secretary, State
11 or local agency on behalf of the Secretary, or
12 accreditation body approved under this sub-
13 section that includes the following:

14 “(i) Equipment verification.

15 “(ii) Evaluation of policies and proce-
16 dures for compliance with accreditation re-
17 quirements.

18 “(iii) Evaluation of personnel quali-
19 fications and credentialing.

20 “(iv) Evaluation of the technical qual-
21 ity of images.

22 “(v) Evaluation of patient reports.

23 “(vi) Evaluation of peer-review mech-
24 anisms and other quality assurance activi-
25 ties.

1 “(vii) Evaluation of quality control
2 procedures, results, and follow-up actions.

3 “(viii) Evaluation of medical physi-
4 cists (or other appropriate professionals
5 chosen by the accreditation body) and
6 magnetic resonance scientist surveys.

7 “(ix) Evaluation of consumer com-
8 plaint mechanisms.

9 “(x) Provision of recommendations for
10 improvement based on findings with re-
11 spect to clauses (i) through (ix).

12 “(B) DIAGNOSTIC IMAGING SERVICES FA-
13 CILITY.—The term ‘diagnostic imaging services
14 facility’ has the meaning given the term ‘facil-
15 ity’ in section 354(a)(3) of the Public Health
16 Service Act (42 U.S.C. 263b(a)(3)) subject to
17 the reference changes specified in paragraph
18 (2), but does not include any facility that does
19 not furnish diagnostic imaging services for
20 which payment may be made under this section.

21 “(C) IMAGE.—The term ‘image’ means the
22 portrayal of internal structures of the human
23 body for the purpose of detecting and deter-
24 mining the presence or extent of disease or in-
25 jury and may be produced through various

1 techniques or modalities, including radiant en-
2 ergy or ionizing radiation and ultrasound and
3 magnetic resonance. Such term does not include
4 image guided procedures.

5 “(D) MEDICAL IMAGING SERVICE.—The
6 term ‘medical imaging service’ means a service
7 that involves the science of an image. Such
8 term does not include image guided proce-
9 dures.”.

10 (b) ADJUSTMENT IN PRACTICE EXPENSE TO RE-
11 FLECT HIGHER PRESUMED UTILIZATION.—Section 1848
12 of the Social Security Act (42 U.S.C. 1395w(b)(4)) is
13 amended—

14 (1) in subsection (b)(4)—

15 (A) in the heading, by striking “RULE”
16 and inserting “RULES”;

17 (B) in subparagraph (B), by striking “sub-
18 paragraph (A)” and inserting “this paragraph”;
19 and

20 (C) by adding at the end the following new
21 subparagraph:

22 “(C) ADJUSTMENT IN PRACTICE EXPENSE
23 TO REFLECT HIGHER PRESUMED UTILIZA-
24 TION.—In computing the number of practice
25 expense relative value units under subsection

1 (c)(2)(C)(ii) with respect to imaging services
2 described in subparagraph (B), the Secretary
3 shall adjust such number of units so it reflects
4 a 75 percent (rather than 50 percent) presumed
5 rate of utilization of imaging equipment.”; and
6 (2) in subsection (c)(2)(B)(v)(II), by inserting
7 “AND OTHER PROVISIONS” after “OPD PAYMENT
8 CAP”

9 (c) ADJUSTMENT IN TECHNICAL COMPONENT “DIS-
10 COUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE
11 BODY PARTS.—Section 1848(b)(4) of such Act is further
12 amended by adding at the end the following new subpara-
13 graph:

14 “(D) ADJUSTMENT IN TECHNICAL COMPO-
15 NENT DISCOUNT ON SINGLE-SESSION IMAGING
16 INVOLVING CONSECUTIVE BODY PARTS.—The
17 Secretary shall increase the reduction in ex-
18 penditures attributable to the multiple proce-
19 dure payment reduction applicable to the tech-
20 nical component for imaging under the final
21 rule published by the Secretary in the Federal
22 Register on November 21, 2005 (42 CFR 405,
23 et al.) from 25 percent to 50 percent.”.

24 (d) ADJUSTMENT IN ASSUMED INTEREST RATE FOR
25 CAPITAL PURCHASES.—Section 1848(b)(4) of such Act is

1 further amended by adding at the end the following new
2 subparagraph:

3 “(E) ADJUSTMENT IN ASSUMED INTEREST
4 RATE FOR CAPITAL PURCHASES.—In computing
5 the practice expense component for imaging
6 services under this section, the Secretary shall
7 change the interest rate assumption for capital
8 purchases of imaging devices to reflect the pre-
9 vailing rate in the market, but in no case higher
10 than 11 percent.”.

11 (e) DISALLOWANCE OF GLOBAL BILLING.—Effective
12 for claims filed for imaging services (as defined in sub-
13 section (b)(4)(B) of section 1848 of the Social Security
14 Act) furnished on or after the first day of the first month
15 that begins more than 1 year after the date of the enact-
16 ment of this Act, the Secretary of Health and Human
17 Services shall not accept (or pay) a claim under such sec-
18 tion unless the claim is made separately for each compo-
19 nent of such services.

20 (f) EFFECTIVE DATE.—Except as otherwise pro-
21 vided, this section, and the amendments made by this sec-
22 tion, shall apply to services furnished on or after January
23 1, 2008.

1 **SEC. 310. REPEAL OF PHYSICIANS ADVISORY COUNCIL.**

2 Section 1868(a) of the Social Security Act (42 U.S.C.
3 1395ee(a)), relating to the Practicing Physicians Advisory
4 Council, is repealed.

5 **TITLE IV—MEDICARE**
6 **ADVANTAGE REFORMS**
7 **Subtitle A—Payment Reform**

8 **SEC. 401. EQUALIZING PAYMENTS BETWEEN MEDICARE AD-**
9 **VANTAGE PLANS AND FEE-FOR-SERVICE**
10 **MEDICARE.**

11 (a) PHASE IN OF PAYMENT BASED ON FEE-FOR-
12 SERVICE COSTS.—Section 1853 of the Social Security Act
13 (42 U.S.C. 1395w-23) is amended—

14 (1) in subsection (j)(1)(A)—

15 (A) by striking “beginning with 2007” and
16 inserting “for 2007 and 2008”; and

17 (B) by inserting after “(k)(1)” the fol-
18 lowing: “, or, beginning with 2009, 1/12 of the
19 blended benchmark amount determined under
20 subsection (l)(1)”; and

21 (2) by adding at the end the following new sub-
22 section:

23 “(l) DETERMINATION OF BLENDED BENCHMARK
24 AMOUNT.—

1 “(1) IN GENERAL.—For purposes of subsection
2 (j), subject to paragraphs (2) and (3), the term
3 ‘blended benchmark amount’ means for an area—

4 “(A) for 2009 the sum of—

5 “(i) $\frac{2}{3}$ of the applicable amount (as
6 defined in subsection (k)(1)) for the area
7 and year; and

8 “(ii) $\frac{1}{3}$ of the amount specified in
9 subsection (c)(1)(D)(i) for the area and
10 year;

11 “(B) for 2010 the sum of—

12 “(i) $\frac{1}{3}$ of the applicable amount for
13 the area and year; and

14 “(ii) $\frac{2}{3}$ of the amount specified in
15 subsection (c)(1)(D)(i) for the area and
16 year; and

17 “(C) for a subsequent year the amount
18 specified in subsection (c)(1)(D)(i) for the area
19 and year.

20 “(2) FEE-FOR-SERVICE PAYMENT FLOOR.—In
21 no case shall the blended benchmark amount for an
22 area and year be less than the amount specified in
23 subsection (c)(1)(D)(i) for the area and year.

1 “(3) EXCEPTION FOR PACE PLANS.—This sub-
2 section shall not apply to payments to a PACE pro-
3 gram under section 1894.”.

4 (b) PHASE IN OF PAYMENT BASED ON IME
5 COSTS.—

6 (1) IN GENERAL.—Section 1853(c)(1)(D)(i) of
7 such Act (42 U.S.C. 1395w-23(c)(1)(D)(i)) is
8 amended by inserting “and costs attributable to pay-
9 ments under section 1886(d)(5)(B)” after
10 “1886(h)”.

11 (2) EFFECTIVE DATE.—The amendment made
12 by paragraph (1) shall apply to the capitation rate
13 for years beginning with 2009.

14 (c) LIMITATION ON PLAN ENROLLMENT IN CASES OF
15 EXCESS BIDS FOR 2009 AND 2010.—

16 (1) IN GENERAL.—In the case of a Medicare
17 Part C organization that offers a Medicare Part C
18 plan in the 50 States or the District of Columbia for
19 which—

20 (A) bid amount described in paragraph (2)
21 for a Medicare Part C plan for 2009 or 2010,
22 exceeds

23 (B) the percent specified in paragraph (4)
24 of the fee-for-service amount described in para-
25 graph (3),

1 the Medicare Part C plan may not enroll any new
2 enrollees in the plan during the annual, coordinated
3 election period (under section 1851(e)(3)(B) of such
4 Act (42 U.S.C. 1395w-21(e)(3)(B)) for the year or
5 during the year (if the enrollment becomes effective
6 during the year).

7 (2) BID AMOUNT FOR PART A AND B SERV-
8 ICES.—

9 (A) IN GENERAL.—Except as provided in
10 subparagraph (B), the bid amount described in
11 this paragraph is the unadjusted Medicare Part
12 C statutory non-drug monthly bid amount (as
13 defined in section 1854(b)(2)(E) of the Social
14 Security Act (42 U.S.C. 1395w-24(b)(2)(E)).

15 (B) TREATMENT OF MSA PLANS.—In the
16 case of an MSA plan (as defined in section
17 1859(b)(3) of the Social Security Act, 42
18 U.S.C. 1935w-28(b)(3)), the bid amount de-
19 scribed in this paragraph is the amount de-
20 scribed in section 1854(a)(3)(A) of such Act
21 (42 U.S.C. 1395w-24(a)(3)(A)).

22 (3) FEE-FOR-SERVICE AMOUNT DESCRIBED.—

23 (A) IN GENERAL.—Subject to subpara-
24 graph (B), the fee-for-service amount described
25 in this paragraph for an Medicare Part C local

1 area is the amount described in section
2 1853(c)(1)(D)(i) of the Social Security Act (42
3 U.S.C. 1395w-23) for such area.

4 (B) TREATMENT OF MULTI-COUNTY
5 PLANS.—In the case of an MA plan the service
6 area for which covers more than one Medicare
7 Part C local area, the fee-for-service amount
8 described in this paragraph is the amount de-
9 scribed in section 1853(c)(1)(D)(i) of the Social
10 Security Act for each such area served, weight-
11 ed for each such area by the proportion of the
12 enrollment of the plan that resides in the coun-
13 ty (as determined based on amounts posted by
14 the Administrator of the Centers for Medicare
15 & Medicaid Services in the April bid notice
16 for the year involved).

17 (4) PERCENTAGE PHASE DOWN.—For purposes
18 of paragraph (1), the percentage specified in this
19 paragraph—

20 (A) for 2009 is 106 percent; and

21 (B) for 2010 is 103 percent.

22 (5) EXEMPTION OF AGE-INS.—For purposes of
23 paragraph (1), the term “new enrollee” with respect
24 to a Medicare Part C plan offered by a Medicare
25 Part C organization, does not include an individual

1 who was enrolled in a plan offered by the organiza-
2 tion in the month immediately before the month in
3 which the individual was eligible to enroll in such a
4 Medicare Part C plan offered by the organization.

5 (d) ANNUAL REBASING OF FEE-FOR-SERVICE
6 RATES.—Section 1853(c)(1)(D)(ii) of the Social Security
7 Act (42 U.S.C. 1395w-23(c)(1)(D)(ii)) is amended—

8 (1) by inserting “(before 2009)” after “for sub-
9 sequent years”; and

10 (2) by inserting before the period at the end the
11 following: “and for each year beginning with 2009”.

12 (e) REPEAL OF PPO STABILIZATION FUND.—Sec-
13 tion 1858 of the Social Security Act (42 U.S.C. 1395) is
14 amended—

15 (1) by striking subsection (e); and

16 (2) in subsection (f)(1), by striking “subject to
17 subsection (e),”.

18 **Subtitle B—Beneficiary Protections**

19 **SEC. 411. NAIC DEVELOPMENT OF MARKETING, ADVER-** 20 **TISING, AND RELATED PROTECTIONS.**

21 (a) IN GENERAL.—Section 1852 of the Social Secu-
22 rity Act (42 U.S.C. 1395w-22) is amended by adding at
23 the end the following new subsection:

24 “(m) APPLICATION OF MODEL MARKETING AND EN-
25 ROLLMENT STANDARDS.—

1 “(1) IN GENERAL.—The National Association
2 of Insurance Commissioners (in this subsection re-
3 ferred to as the ‘NAIC’) is requested to develop, and
4 to submit to the Secretary of Health and Human
5 Services not later than 12 months after the date of
6 the enactment of this Act, model regulations (in this
7 section referred to as ‘model regulations’) regarding
8 Medicare plan marketing, enrollment, broker and
9 agent training and certification, agent and broker
10 commissions, and market conduct by plans, agents
11 and brokers for implementation (under paragraph
12 (7)) under this part and part D, including for en-
13 forcement by States under section 1856(b)(3).

14 “(2) MARKETING GUIDELINES.—

15 “(A) IN GENERAL.—The model regulations
16 shall address the sales and advertising tech-
17 niques used by Medicare private plans, agents
18 and brokers in selling plans, including defining
19 and prohibiting cold calls, unsolicited door-to-
20 door sales, cross-selling, and co-branding.

21 “(B) SPECIAL CONSIDERATIONS.—The
22 model regulations shall specifically address the
23 marketing—

1 “(i) of plans to full benefit dual-elig-
2 ble individuals and qualified medicare
3 beneficiaries;

4 “(ii) of plans to populations with lim-
5 ited English proficiency;

6 “(iii) of plans to beneficiaries in sen-
7 ior living facilities; and

8 “(iv) of plans at educational events.

9 “(3) ENROLLMENT GUIDELINES.—

10 “(A) IN GENERAL.—The model regulations
11 shall address the disclosures Medicare private
12 plans, agents, and brokers must make when en-
13 rolling beneficiaries, and a process—

14 “(i) for affirmative beneficiary sign
15 off before enrollment in a plan; and

16 “(ii) in the case of Medicare Part C
17 plans, for plans to conduct a beneficiary
18 call-back to confirm beneficiary sign off
19 and enrollment.

20 “(B) SPECIFIC CONSIDERATIONS.—The
21 model regulations shall specially address bene-
22 ficiary understanding of the Medicare plan
23 through required disclosure (or beneficiary
24 verification) of each of the following:

1 “(i) The type of Medicare private plan
2 involved.

3 “(ii) Attributes of the plan, including
4 premiums, cost sharing, formularies (if ap-
5 plicable), benefits, and provider access lim-
6 itations in the plan.

7 “(iii) Comparative quality of the plan.

8 “(iv) The fact that plan attributes
9 may change annually.

10 “(4) APPOINTMENT, CERTIFICATION AND
11 TRAINING OF AGENTS AND BROKERS.—The model
12 regulations shall establish procedures and require-
13 ments for appointment, certification (and periodic
14 recertification), and training of agents and brokers
15 that market or sell Medicare private plans consistent
16 with existing State appointment and certification
17 procedures and with this paragraph.

18 “(5) AGENT AND BROKER COMMISSIONS.—

19 “(A) IN GENERAL.—The model regulations
20 shall establish standards for fair and appro-
21 priate commissions for agents and brokers con-
22 sistent with this paragraph.

23 “(B) LIMITATION ON TYPES OF COMMIS-
24 SION.—The model regulations shall specifically
25 prohibit the following:

1 “(i) Differential commissions—

2 “(I) for Medicare Part C plans
3 based on the type of Medicare private
4 plan; or

5 “(II) prescription drug plans
6 under part D based on the type of
7 prescription drug plan.

8 “(ii) Commissions in the first year
9 that are more than 200 percent of subse-
10 quent year commissions.

11 “(iii) The payment of extra bonuses
12 or incentives (such as trips, gifts, and
13 other non-commission cash payments).

14 “(C) AGENT DISCLOSURE.—In developing
15 the model regulations, the NAIC shall consider
16 requiring agents and brokers to disclose com-
17 missions to a beneficiary upon request of the
18 beneficiary before enrollment.

19 “(D) PREVENTION OF FRAUD.—The model
20 regulations shall consider the opportunity for
21 fraud and abuse and beneficiary steering in set-
22 ting standards under this paragraph and shall
23 provide for the ability of State commissioners to
24 investigate commission structures.

25 “(6) MARKET CONDUCT.—

1 “(A) IN GENERAL.—The model regulations
2 shall establish standards for the market con-
3 duct of organizations offering Medicare private
4 plans, and of agents and brokers selling such
5 plans, and for State review of plan market con-
6 duct.

7 “(B) MATTERS TO BE INCLUDED.—Such
8 standards shall include standards for—

9 “(i) timely payment of claims;

10 “(ii) beneficiary complaint reporting
11 and disclosure; and

12 “(iii) State reporting of market con-
13 duct violations and sanctions.

14 “(7) IMPLEMENTATION.—

15 “(A) PUBLICATION OF NAIC MODEL REGU-
16 LATIONS.—If the model regulations are sub-
17 mitted on a timely basis under paragraph (1)—

18 “(i) the Secretary shall publish them
19 in the Federal Register upon receipt and
20 request public comment on the issue of
21 whether such regulations are consistent
22 with the requirements established in this
23 subsection for such regulations;

24 “(ii) not later than 6 months after the
25 date of such publication, the Secretary

1 shall determine whether such regulations
2 are so consistent with such requirements
3 and shall publish notice of such determina-
4 tion in the Federal Register; and

5 “(iii) if the Secretary makes the de-
6 termination under clause (ii) that such reg-
7 ulations are consistent with such require-
8 ments, in the notice published under clause
9 (ii) the Secretary shall publish notice of
10 adoption of such model regulations as con-
11 stituting the marketing and enrollment
12 standards adopted under this subsection to
13 be applied under this title; and

14 “(iv) if the Secretary makes the deter-
15 mination under such clause that such regu-
16 lations are not consistent with such re-
17 quirements, the procedures of clauses (ii)
18 and (iii) of subparagraph (B) shall apply
19 (in relation to the notice published under
20 clause (ii)), in the same manner as such
21 clauses would apply in the case of publica-
22 tion of a notice under subparagraph (B)(i).

23 “(B) NO MODEL REGULATIONS.—If the
24 model regulations are not submitted on a timely
25 basis under paragraph (1)—

1 “(i) the Secretary shall publish notice
2 of such fact in the Federal Register;

3 “(ii) not later than 6 months after the
4 date of publication of such notice, the Sec-
5 retary shall propose regulations that pro-
6 vide for marketing and enrollment stand-
7 ards that incorporate the requirements of
8 this subsection for the model regulations
9 and request public comments on such pro-
10 posed regulations; and

11 “(iii) not later than 6 months after
12 the date of publication of such proposed
13 regulations, the Secretary shall publish
14 final regulations that shall constitute the
15 marketing and enrollment standards
16 adopted under this subsection to be applied
17 under this title.

18 “(C) REFERENCES TO MARKETING AND
19 ENROLLMENT STANDARDS.—In this title, a ref-
20 erence to marketing and enrollment standards
21 adopted under this subsection is deemed a ref-
22 erence to the regulations constituting such
23 standards adopted under subparagraph (A) or
24 (B), as the case may be.

1 “(D) EFFECTIVE DATE OF STANDARDS.—

2 In order to provide for the orderly and timely
3 implementation of marketing and enrollment
4 standards adopted under this subsection, the
5 Secretary, in consultation with the NAIC, shall
6 specify (by program instruction or otherwise)
7 effective dates with respect to all components of
8 such standards consistent with the following:

9 “(i) In the case of components that
10 relate predominantly to operations in rela-
11 tion to Medicare private plans, the effective
12 date shall be for plan years beginning on
13 or after such date (not later than 1 year
14 after the date of promulgation of the
15 standards) as the Secretary specifies.

16 “(ii) In the case of other components,
17 the effective date shall be such date, not
18 later than 1 year after the date of promul-
19 gation of the standards, as the Secretary
20 specifies.

21 “(E) CONSULTATION.— In promulgating
22 marketing and enrollment standards under this
23 paragraph, the NAIC or Secretary shall consult
24 with a working group composed of representa-
25 tives of issuers of Medicare private plans, con-

1 sumer groups, medicare beneficiaries, State
2 Health Insurance Assistance Programs, and
3 other qualified individuals. Such representatives
4 shall be selected in a manner so as to assure
5 balanced representation among the interested
6 groups.

7 “(8) ENFORCEMENT.—

8 “(A) IN GENERAL.—Any Medicare private
9 plan that violates marketing and enrollment
10 standards is subject to sanctions under section
11 1857(g).

12 “(B) STATE RESPONSIBILITIES.—Nothing
13 in this subsection or section 1857(g) shall pro-
14 hibit States from imposing sanctions against
15 Medicare private plans, agents, or brokers for
16 violations of the marketing and enrollment
17 standards adopted under section 1852(m).
18 States shall have the sole authority to regulate
19 agents and brokers.

20 “(9) MEDICARE PRIVATE PLAN DEFINED.—In
21 this subsection, the term ‘Medicare private plan’
22 means a Medicare Part C plan and a prescription
23 drug plan under part D.”.

24 (b) EXPANSION OF EXCEPTION TO PREEMPTION OF
25 STATE ROLE.—

1 (1) IN GENERAL.—Section 1856(b)(3) of the
2 Social Security Act (42 U.S.C. 1395w-26(b)(3)) is
3 amended by striking “(other than State licensing
4 laws or State laws relating to plan solvency)” and
5 inserting “(other than State laws relating to licens-
6 ing or plan solvency and State laws or regulations
7 adopting the marketing and enrollment standards
8 adopted under section 1852(m)).”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall apply to plans offered on or
11 after July 1, 2008.

12 (c) APPLICATION TO PRESCRIPTION DRUG PLANS.—

13 (1) IN GENERAL.—Section 1860D–1 of such
14 Act is amended by adding at the end the following
15 new subsection:

16 “(d) APPLICATION OF MARKETING AND ENROLL-
17 MENT STANDARDS.—The marketing and enrollment
18 standards adopted under section 1852(m) shall apply to
19 prescription drug plans (and sponsors of such plans) in
20 the same manner as they apply to Medicare Part C plans
21 and organizations offering such plans.”.

22 (2) REFERENCE TO CURRENT LAW PROVI-
23 SIONS.—The amendment made by subsection (a)
24 and (b) apply, pursuant to section 1860D–
25 1(b)(1)(B)(ii) of the Social Security Act (42 U.S.C.

1 1395w-101(b)(1)(B)(ii)), to prescription drug plans
2 under part D of title XVIII of such Act.

3 (d) CONTRACT REQUIREMENT TO MEET MARKETING
4 AND ADVERTISING STANDARDS.—

5 (1) IN GENERAL.—Section 1857(d) of the So-
6 cial Security Act (42 U.S.C. 1395w-27(d)), as
7 amended by subsection (b)(1), is further amended by
8 adding at the end the following new paragraph:

9 “(7) MARKETING AND ADVERTISING STAND-
10 ARDS.—The contract shall require the organization
11 to meet all standards adopted under section
12 1852(m) (including those enforced by the State in-
13 volved pursuant to section 1856(b)(3)) relating to
14 marketing and advertising conduct”.

15 (2) EFFECTIVE DATE.—The amendment made
16 by paragraph (1) shall apply to contracts for plan
17 years beginning on or after January 1, 2011.

18 (e) APPLICATION OF SANCTIONS.—

19 (1) APPLICATION TO VIOLATION OF MARKETING
20 AND ENROLLMENT STANDARDS.—Section 1857(g) of
21 such Act (42 U.S.C. 1395w-27(g)) is amended—

22 (A) by striking “or” at the end of subpara-
23 graph (F);

24 (B) by adding “or” at the end of subpara-
25 graph (G); and

1 (C) by inserting after subparagraph (G)
2 the following new subparagraph:

3 “(H) violates marketing and enrollment
4 standards adopted under section 1852(m);”.

5 (2) ENHANCED CIVIL MONEY SANCTIONS.—
6 Such section is further amended—

7 (A) in paragraph (2)(A), by striking
8 “\$25,000”, “\$100,000”, and “\$15,000” and
9 inserting “\$50,000”, “\$200,000”, and
10 “\$30,000”, respectively; and

11 (B) in subparagraphs (A), (B), and (D) of
12 paragraph (3), by striking “\$25,000”,
13 “\$10,000”, and “\$100,000”, respectively, and
14 inserting “\$50,000”, “\$20,000”, and
15 “\$200,000”, respectively.

16 (3) EFFECTIVE DATE.—The amendments made
17 by paragraph (2) shall apply to violations occurring
18 on or after the date of the enactment of this Act.

19 (f) DISCLOSURE OF MARKET AND ADVERTISING
20 CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—Sec-
21 tion 1857 of such Act is amended by adding at the end
22 the following new subsection

23 “(j) DISCLOSURE OF MARKET AND ADVERTISING
24 CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—For
25 years beginning with 2009, the Secretary shall post on its

1 public website for the Medicare program an annual report
2 that—

3 “(1) lists each MA organization for which the
4 Secretary made during the year a determination
5 under subsection (c)(2) the basis of which is de-
6 scribed in paragraph (1)(E); and

7 “(2) that describes any applicable sanctions
8 under subsection (g) applied to such organization
9 pursuant to such determination.”.

10 (g) STANDARD DEFINITIONS OF BENEFITS AND
11 FORMATS FOR USE IN MARKETING MATERIALS.—Section
12 1851(h) of such Act (42 U.S.C. 1395w-21(h)) is amended
13 by adding at the end the following new paragraph:

14 “(6) STANDARD DEFINITIONS OF BENEFITS
15 AND FORMATS FOR USE IN MARKETING MATE-
16 RIALS.—

17 “(A) IN GENERAL.—Not later than Janu-
18 ary 1, 2010, the Secretary, in consultation with
19 the National Association of Insurance Commis-
20 sioners and a working group of the type de-
21 scribed in section 1852(m)(7)(E), shall develop
22 standard descriptions and definitions for bene-
23 fits under this title for use in marketing mate-
24 rial distributed by Medicare Part C organiza-

1 tions and formats for including such descrip-
2 tions in such marketing material.

3 “(B) REQUIRED USE OF STANDARD DEFINITIONS.— For plan years beginning on or
4 NITIONS.— For plan years beginning on or
5 after January 1, 2011, the Secretary shall dis-
6 approve the distribution of marketing material
7 under paragraph (1)(B) if such marketing ma-
8 terial does not use, without modification, the
9 applicable descriptions and formats specified
10 under subparagraph (A).”.

11 (h) SUPPORT FOR STATE HEALTH INSURANCE AS-
12 SISTANCE PROGRAMS (SHIPS).—Section 1857(e)(2) of
13 the Social Security Act (42 U.S.C. 1395w-27(e)(2)) is
14 amended—

15 (1) in subparagraph (B), by adding at the end
16 the following: “Of the amounts so collected, no less
17 than \$55,000,000 for fiscal year 2009, \$65,000,000
18 for fiscal year 2010, \$75,000,000 for fiscal year
19 2011, and \$85,000,000 for fiscal year 2012 shall be
20 used to support Medicare Part C and Part D coun-
21 seling and assistance provided by State Health In-
22 surance Assistance Programs.”;

23 (2) in subparagraph (C)—

24 (A) by striking “and” after
25 “\$100,000,000”; and

1 (B) by striking “an amount equal to
2 \$200,000,000” and inserting “and ending with
3 fiscal year 2008 an amount equal to
4 \$200,000,000, for fiscal year 2009 an amount
5 equal to \$255,000,000, for fiscal year 2010 an
6 amount equal to \$265,000,000, for fiscal year
7 2011 an amount equal to \$275,000,000, and
8 for fiscal year 2012 an amount equal to
9 \$285,000,000”; and

10 (3) in subparagraph (D)(ii)—

11 (A) by striking “and” at the end of sub-
12 clause (IV);

13 (B) in subclause (V), by striking the period
14 at the end and inserting “before fiscal year
15 2009; and”; and

16 (C) by adding at the end the following new
17 subclauses:

18 “(VI) for fiscal year 2009 and each
19 succeeding fiscal year the applicable por-
20 tion (as so defined) of the amount specified
21 in subparagraph (C) for that fiscal year.”.

22 **SEC. 412. LIMITATION ON OUT-OF-POCKET COSTS FOR INDI-**
23 **VIDUAL HEALTH SERVICES.**

24 (a) IN GENERAL.—Section 1852(a)(1) of the Social
25 Security Act (42 U.S.C. 1395w-22(a)(1)) is amended—

1 (1) in subparagraph (A), by inserting before the
2 period at the end the following: “with cost-sharing
3 that is no greater (and may be less) than the cost-
4 sharing that would otherwise be imposed under such
5 program option”;

6 (2) in subparagraph (B)(i), by striking “ or an
7 actuarially equivalent level of cost-sharing as deter-
8 mined in this part”; and

9 (3) by amending clause (ii) of subparagraph
10 (B) to read as follows:

11 “(ii) PERMITTING USE OF FLAT CO-
12 PAYMENT OR PER DIEM RATE.—Nothing in
13 clause (i) shall be construed as prohibiting
14 a Medicare part C plan from using a flat
15 copayment or per diem rate, in lieu of the
16 cost-sharing that would be imposed under
17 part A or B, so long as the amount of the
18 cost-sharing imposed does not exceed the
19 amount of the cost-sharing that would be
20 imposed under the respective part if the in-
21 dividual were not enrolled in a plan under
22 this part.”.

23 (b) LIMITATION FOR DUAL ELIGIBLES AND QUALI-
24 FIED MEDICARE BENEFICIARIES.—Section 1852(a) of

1 such Act is amended by adding at the end the following
2 new paragraph:

3 “(7) LIMITATION ON COST-SHARING FOR DUAL
4 ELIGIBLES AND QUALIFIED MEDICARE BENE-
5 FICIARIES.—In the case of a individual who is a full-
6 benefit dual eligible individual (as defined in section
7 1935(c)(6)) or a qualified medicare beneficiary (as
8 defined in section 1905(p)(1)) who is enrolled in a
9 Medicare Part C plan, the plan may not impose
10 cost-sharing that exceeds the amount of cost-sharing
11 that would be permitted with respect to the indi-
12 vidual under this title and title XIX if the individual
13 were not enrolled with such plan.”.

14 (c) EFFECTIVE DATES.—

15 (1) The amendments made by subsection (a)
16 shall apply to plan years beginning on or after Janu-
17 ary 1, 2009.

18 (2) The amendments made by subsection (b)
19 shall apply to plan years beginning on or after Janu-
20 ary 1, 2008.

21 **SEC. 413. MA PLAN ENROLLMENT MODIFICATIONS.**

22 (a) IMPROVED PLAN ENROLLMENT,
23 DISENROLLMENT, AND CHANGE OF ENROLLMENT.—

24 (1) CONTINUOUS OPEN ENROLLMENT FOR
25 FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS AND

1 QUALIFIED MEDICARE BENEFICIARIES (QMB).—Sec-
2 tion 1851(e)(2)(D) of the Social Security Act (42
3 U.S.C. 1395w-21(e)(2)(D)) is amended—

4 (A) in the heading, by inserting “;”, FULL-
5 BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND
6 QUALIFIED MEDICARE BENEFICIARIES” after
7 “INSTITUTIONALIZED INDIVIDUALS”; and

8 (B) in the matter before clause (i), by in-
9 serting “, a full-benefit dual eligible individual
10 (as defined in section 1935(c)(6)), or a quali-
11 fied medicare beneficiary (as defined in section
12 1905(p)(1))” after “institutionalized (as defined
13 by the Secretary”); and

14 (C) in clause (i), by inserting “or
15 disenroll” after “enroll”.

16 (2) SPECIAL ELECTION PERIODS FOR ADDI-
17 TIONAL CATEGORIES OF INDIVIDUALS.—Section
18 1851(e)(4) of such Act (42 U.S.C. 1395w(e)(4)) is
19 amended—

20 (A) in subparagraph (C), by striking at the
21 end “or”;

22 (B) in subparagraph (D), by inserting “,
23 taking into account the health or well-being of
24 the individual” before the period and redesign-

1 nating such subparagraph as subparagraph (G);
2 and

3 (C) by inserting after subparagraph (C)
4 the following new subparagraphs:

5 “(D) the individual is described in section
6 1902(a)(10)(E)(iii) (relating to specified low-in-
7 come medicare beneficiaries); or

8 “(E) the individual is enrolled in an MA
9 plan and enrollment in the plan is suspended
10 under paragraph (2)(B) or (3)(C) of section
11 1857(g) because of a failure of the plan to meet
12 applicable requirements.”.

13 (3) ELIMINATION OF CONTINUOUS OPEN EN-
14 ROLLMENT OF ORIGINAL FEE-FOR-SERVICE ENROLL-
15 EES IN MEDICARE ADVANTAGE NON-PRESCRIPTION
16 DRUG PLANS.—Subparagraph (E) of section
17 1851(e)(2) of the Social Security Act, as added by
18 section 206 of division B of the Tax Relief and
19 Health Care Act of 2006 (Public Law 109–432), is
20 repealed.

21 (4) EFFECTIVE DATE.—The amendments made
22 by this subsection shall take effect on the date of the
23 enactment of this Act.

24 (b) ACCESS TO MEDIGAP COVERAGE FOR INDIVID-
25 UALS WHO LEAVE MA PLANS.—

1 (1) IN GENERAL.—Section 1882(s)(3) of the
2 Social Security Act (42 U.S.C. 1395ss(s)(3)) is
3 amended—

4 (A) in each of clauses (v)(III) and (vi) sub-
5 paragraph (B), by striking “12 months” and
6 inserting “24 months”; and

7 (B) in each of subclauses (I) and (II) of
8 subparagraph (F)(i), by striking “12 months”
9 and inserting “24 months”.

10 (2) EFFECTIVE DATE.—The amendments made
11 by paragraph (1) shall apply to terminations of en-
12 rollments in MA plans occurring on or after the date
13 of the enactment of this Act.

14 (c) IMPROVED ENROLLMENT POLICIES.—

15 (1) NO AUTO-ENROLLMENT OF MEDICAID
16 BENEFICIARIES.—

17 (A) IN GENERAL.—Section 1851(e) of such
18 Act (42 U.S.C. 1395w-21(e)) is amended by
19 adding at the end the following new paragraph:
20 “(7) NO AUTO-ENROLLMENT OF MEDICAID

21 BENEFICIARIES.—In no case may the Secretary pro-
22 vide for the enrollment in a MA plan of a Medicare
23 Advantage eligible individual who is eligible to re-
24 ceive medical assistance under title XIX as a full-
25 benefit dual eligible individual or a qualified medi-

1 care beneficiary, without the affirmative application
2 of such individual (or authorized representative of
3 the individual) to be enrolled in such plan.”.

4 (B) NO APPLICATION TO PRESCRIPTION
5 DRUG PLANS.—Section 1860D–1(b)(1)(B)(iii)
6 of such Act (42 U.S.C. 1395w-
7 101(b)(1)(B)(iii)) is amended—

8 (i) by striking “paragraph (2) and”
9 and by inserting “paragraph (2),”; and

10 (ii) by inserting “, and paragraph
11 (7),” after “paragraph (4)”.

12 (C) EFFECTIVE DATE.—The amendments
13 made by this paragraph shall apply to enroll-
14 ments that are effective on or after the date of
15 the enactment of this Act.

16 **SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN**
17 **ADMINISTRATIVE COSTS.**

18 (a) DISCLOSURE OF MEDICAL LOSS RATIOS AND
19 OTHER EXPENSE DATA.—Section 1851 of the Social Se-
20 curity Act (42 U.S.C. 1395w-21) is amended by adding
21 at the end the following new subsection:

22 “(j) PUBLICATION OF MEDICAL LOSS RATIOS AND
23 OTHER COST-RELATED INFORMATION.—

24 “(1) IN GENERAL.—The Secretary shall pub-
25 lish, not later than October 1 of each year (begin-

1 ning with 2009), for each Medicare Part C plan con-
2 tract, the following:

3 “(A) The medical loss ratio of the plan in
4 the previous year.

5 “(B) The per enrollee payment under this
6 part to the plan, as adjusted to reflect a risk
7 score (based on factors described in section
8 1853(a)(1)(C)(i) of 1.0.

9 “(C) The average risk score (as so based).

10 “(2) SUBMISSION OF DATA.—

11 “(A) IN GENERAL.—Each Medicare Part C
12 organization shall submit to the Secretary, in a
13 form and manner specified by the Secretary,
14 data necessary for the Secretary to publish the
15 information described in paragraph (1) on a
16 timely basis, including the information de-
17 scribed in paragraph (3).

18 “(B) DATA FOR 2008 AND 2009.—The data
19 submitted under subparagraph (A) for 2008
20 and for 2009 shall be consistent in content with
21 the data reported as part of the Medicare Part
22 C plan bid in June 2007 for 2008.

23 “(C) MEDICAL LOSS RATIO DATA.—The
24 data to be submitted under subparagraph (A)
25 relating to medical loss ratio for a year—

1 “(i) shall be submitted not later than
2 June 1 of the following year; and

3 “(ii) beginning with 2010, shall be
4 submitted based on the standardized ele-
5 ments and definitions developed under
6 paragraph (4).

7 “(D) AUDITED DATA.—Data submitted
8 under this paragraph shall be data that has
9 been audited by an independent third party
10 auditor.

11 “(3) MLR INFORMATION.—The information de-
12 scribed in this paragraph with respect to a Medicare
13 Part C plan for a year is as follows:

14 “(A) The costs for the plan in the previous
15 year for each of the following:

16 “(i) Total medical expenses, sepa-
17 rately indicated for benefits for the original
18 medicare fee-for-service program option
19 and for supplemental benefits.

20 “(ii) Non-medical expenses, shown
21 separately for each of the following cat-
22 egories of expenses:

23 “(I) Marketing and sales.

24 “(II) Direct administration.

25 “(III) Indirect administration.

1 “(IV) Net cost of private reinsur-
2 ance.

3 “(B) Gain or loss margin.

4 “(C) Total revenue requirement, computed
5 as the total of medical and nonmedical expenses
6 and gain or loss margin, multiplied by the gain
7 or loss margin.

8 “(D) Percent of revenue ratio, computed
9 as the total revenue requirement expressed as a
10 percentage of revenue.

11 “(4) DEVELOPMENT OF DATA REPORTING
12 STANDARDS.—

13 “(A) IN GENERAL.—The Secretary shall
14 develop and implement standardized data ele-
15 ments and definitions for reporting under this
16 subsection, for contract years beginning with
17 2010, of data necessary for the calculation of
18 the medical loss ratio for Medicare Part C
19 plans. Not later than December 31, 2008, the
20 Secretary shall publish a report describing the
21 elements and definitions so developed.

22 “(B) CONSULTATION.—The Secretary
23 shall consult with representatives of Medicare
24 Part C organizations, experts on health plan ac-
25 counting systems, and representatives of the

1 National Association of Insurance Commis-
2 sioners, in the development of such data ele-
3 ments and definitions

4 “(5) MEDICAL LOSS RATIO DEFINED.—For
5 purposes of this part, the term ‘medical loss ratio’
6 means, with respect to an MA plan for a year, the
7 ratio of—

8 “(A) the aggregate benefits (excluding
9 nonmedical expenses described in paragraph
10 (3)(A)(ii)) paid under the plan for the year, to

11 “(B) the aggregate amount of premiums
12 (including basic and supplemental beneficiary
13 premiums) and payments made under sections
14 1853 and 1860D–15) collected for the plan and
15 year.

16 Such ratio shall be computed without regard to
17 whether the benefits or premiums are for required or
18 supplemental benefits under the plan.”.

19 (b) AUDIT OF ADMINISTRATIVE COSTS AND COMPLI-
20 ANCE WITH THE FEDERAL ACQUISITION REGULATION.—

21 (1) IN GENERAL.—Section 1857(d)(2)(B) of
22 such Act (42 U.S.C. 1395w-27(d)(2)(B)) is amend-
23 ed—

24 (A) by striking “or (ii)” and inserting
25 “(ii)”; and

1 (B) by inserting before the period at the
2 end the following: “, or (iii) to compliance with
3 the requirements of subsection (e)(4) and the
4 extent to which administrative costs comply
5 with the applicable requirements for such costs
6 under the Federal Acquisition Regulation”.

7 (2) EFFECTIVE DATE.—The amendments made
8 by this subsection shall apply for contract years be-
9 ginning after the date of the enactment of this Act.

10 (c) MINIMUM MEDICAL LOSS RATIO.—Section
11 1857(e) of the Social Security Act (42 U.S.C. 1395w-
12 27(e)) is amended by adding at the end the following new
13 paragraph:

14 “(4) REQUIREMENT FOR MINIMUM MEDICAL
15 LOSS RATIO.—If the Secretary determines for a con-
16 tract year (beginning with 2010) that an MA plan
17 has failed to have a medical loss ratio (as defined in
18 section 1851(j)(4)) of at least .85—

19 “(A) for that contract year, the Secretary
20 shall reduce the blended benchmark amount
21 under subsection (l) for the second succeeding
22 contract year by the numer of percentage points
23 by which such loss ratio was less than 85 per-
24 cent;

1 “(B) for 3 consecutive contract years, the
2 Secretary shall not permit the enrollment of
3 new enrollees under the plan for coverage dur-
4 ing the second succeeding contract year; and

5 “(C) the Secretary shall terminate the plan
6 contract if the plan fails to have such a medical
7 loss ratio for 5 consecutive contract years.”.

8 (d) INFORMATION ON MEDICARE PART C PLAN EN-
9 ROLLMENT AND SERVICES.—Section 1851 of such Act, as
10 amended by subsection (a), is further amended by adding
11 at the end the following new subsection:

12 “(k) PUBLICATION OF ENROLLMENT AND OTHER IN-
13 FORMATION.—

14 “(1) MONTHLY PUBLICATION OF PLAN-SPE-
15 CIFIC ENROLLMENT DATA.—The Secretary shall
16 publish (on the public website of the Centers for
17 Medicare & Medicaid Services or otherwise) not later
18 than 30 days after the end of each month (beginning
19 with January 2008) on the actual enrollment in each
20 Medicare Part C plan by contract and by county.

21 “(2) AVAILABILITY OF OTHER INFORMATION.—
22 The Secretary shall make publicly available data and
23 other information in a format that may be readily
24 used for analysis of the Medicare Part C program
25 under this part and will contribute to the under-

1 standing of the organization and operation of such
2 program.”.

3 (e) MEDPAC REPORT ON VARYING MINIMUM MED-
4 ICAL LOSS RATIOS.—

5 (1) STUDY.—The Medicare Payment Advisory
6 Commission shall conduct a study of the need and
7 feasibility of providing for different minimum medical
8 loss ratios for different types of Medicare Part C
9 plans, including coordinated care plans, group model
10 plans, coordinated care independent practice associa-
11 tion plans, preferred provider organization plans,
12 and private fee-for-services plans.

13 (2) REPORT.—Not later than 1 year after the
14 date of the enactment of this Act, submit to Con-
15 gress a report on the study conducted under para-
16 graph (1).

17 **Subtitle C—Quality and Other** 18 **Provisions**

19 **SEC. 421. REQUIRING ALL MA PLANS TO MEET EQUAL**
20 **STANDARDS.**

21 (a) COLLECTION AND REPORTING OF INFORMA-
22 TION.—

23 (1) IN GENERAL.—Section 1852(e)(1) of the
24 Social Security Act (42 U.S.C. 1395w-112(e)(1)) is

1 amended by striking “(other than an MA private
2 fee-for-service plan or an MSA plan)”.

3 (2) REPORTING FOR PRIVATE FEE-FOR-SERV-
4 ICES AND MSA PLANS.—Section 1852(e)(3) of such
5 Act is amended by adding at the end the following
6 new subparagraph:

7 “(C) DATA COLLECTION REQUIREMENTS
8 BY PRIVATE FEE-FOR-SERVICE PLANS AND MSA
9 PLANS.—

10 “(i) USING MEASURES FOR PPOS FOR
11 CONTRACT YEAR 2009.—For contract year
12 2009, the Medicare Part C organization of-
13 fering a private fee-for-service plan or an
14 MSA plan shall submit to the Secretary for
15 such plan the same information on the
16 same performance measures for which such
17 information is required to be submitted for
18 Medicare Part C plans that are preferred
19 provider organization plans for that year.

20 “(ii) APPLICATION OF SAME MEAS-
21 URES AS COORDINATED CARE PLANS BE-
22 GINNING IN CONTRACT YEAR 2010.—For a
23 contract year beginning with 2010, a Medi-
24 care Part C organization offering a private
25 fee-for-service plan or an MSA plan shall

1 submit to the Secretary for such plan the
2 same information on the same performance
3 measures for which such information is re-
4 quired to be submitted for such contract
5 year Medicare Part C plans described in
6 section 1851(a)(2)(A)(i) for contract year
7 such contract year.”.

8 (3) EFFECTIVE DATE.—The amendment made
9 by paragraph (1) shall apply to contract years begin-
10 ning on or after January 1, 2009.

11 (b) EMPLOYER PLANS.—

12 (1) IN GENERAL.—The first sentence of para-
13 graph (2) of section 1857(i) of such Act (42 U.S.C.
14 1395w-27(i)) is amended by inserting before the pe-
15 riod at the end the following: “, but only if 90 per-
16 cent of the Medicare part C eligible individuals en-
17 rolled under such plan reside in a county in which
18 the Medicare Part C organization offers a Medicare
19 Part C local plan”.

20 (2) LIMITATION ON APPLICATION OF WAIVER
21 AUTHORITY.—Paragraphs (1) and (2) of such sec-
22 tion are each amended by inserting “that were in ef-
23 fect before the date of the enactment of the Chil-
24 dren’s Health and Medicare Protection Act of 2007”
25 after “waive or modify requirements”.

(3) EFFECTIVE DATES.—The amendment made by paragraph (1) shall apply for plan years beginning on or after January 1, 2009, and the amendments made by paragraph (2) shall take effect on the date of the enactment of this Act.

SEC. 422. DEVELOPMENT OF NEW QUALITY REPORTING MEASURES ON RACIAL DISPARITIES.

(a) NEW QUALITY REPORTING MEASURES.—

(1) IN GENERAL.—Section 1852(e)(3) of the Social Security Act (42 U.S.C. 1395w-22(e)(3)), as amended by section 421(a)(2), is amended—

(A) in subparagraph (B)—

(i) in clause (i), by striking “The Secretary” and inserting “Subject to subparagraph (D), the Secretary”; and

(ii) in clause (ii), by inserting “and subparagraph (C)” after “clause (iii)”; and
(B) by adding at the end the following new

subparagraph:

“(D) ADDITIONAL QUALITY REPORTING MEASURES.—

“(i) IN GENERAL.—The Secretary shall develop by October 1, 2009, quality measures for Medicare Part C plans that measure disparities in the amount and

1 quality of health services provided to racial
2 and ethnic minorities.

3 “(ii) DATA TO MEASURE RACIAL AND
4 ETHNIC DISPARITIES IN THE AMOUNT AND
5 QUALITY OF CARE PROVIDED TO ENROLL-
6 EES.—The Secretary shall provide for
7 Medicare Part C organizations to submit
8 data under this paragraph, including data
9 similar to those submitted for other quality
10 measures, that permits analysis of dispari-
11 ties among racial and ethnic minorities in
12 health services, quality of care, and health
13 status among Medicare Part C plan enroll-
14 ees for use in submitting the reports under
15 paragraph (5).”.

16 (2) EFFECTIVE DATE.—The amendments made
17 by this subsection shall apply to reporting of quality
18 measures for plan years beginning on or after Janu-
19 ary 1, 2010.

20 (b) BIENNIAL REPORT ON RACIAL AND ETHNIC MI-
21 NORITIES.—Section 1852(e) of such Act (42 U.S.C.
22 1395w-22(e)) is amended by adding at the end the fol-
23 lowing new paragraph:

24 “(5) REPORT TO CONGRESS.—

1 “(A) IN GENERAL.—Not later than 2 years
2 after the date of the enactment of this para-
3 graph, and biennially thereafter, the Secretary
4 shall submit to Congress a report regarding
5 how quality assurance programs conducted
6 under this subsection measure and report on
7 disparities in the amount and quality of health
8 care services furnished to racial and ethnic mi-
9 norities.

10 “(B) CONTENTS OF REPORT.—Each such
11 report shall include the following:

12 “(i) A description of the means by
13 which such programs focus on such racial
14 and ethnic minorities.

15 “(ii) An evaluation of the impact of
16 such programs on eliminating health dis-
17 parities and on improving health outcomes,
18 continuity and coordination of care, man-
19 agement of chronic conditions, and con-
20 sumer satisfaction.

21 “(iii) Recommendations on ways to re-
22 duce clinical outcome disparities among ra-
23 cial and ethnic minorities.

24 “(iv) Data for each MA plan from
25 HEDIS and other source reporting the dis-

1 parities in the amount and quality of
2 health services furnished to racial and eth-
3 nic minorities.”.

4 **SEC. 423. STRENGTHENING AUDIT AUTHORITY.**

5 (a) FOR PART C PAYMENTS RISK ADJUSTMENT.—
6 Section 1857(d)(1) of the Social Security Act (42 U.S.C.
7 1395w-27(d)(1)) is amended by inserting after “section
8 1858(c)” the following: “, and data submitted with re-
9 spect to risk adjustment under section 1853(a)(3)”.

10 (b) ENFORCEMENT OF AUDITS AND DEFICI-
11 CIENCIES.—

12 (1) IN GENERAL.—Section 1857(e) of such Act
13 is amended by adding at the end the following new
14 paragraph:

15 “(4) ENFORCEMENT OF AUDITS AND DEFICI-
16 CIENCIES.—

17 “(A) INFORMATION IN CONTRACT.—The
18 Secretary shall require that each contract with
19 a Medicare Part C organization under this sec-
20 tion shall include terms that inform the organi-
21 zation of the provisions in subsection (d).

22 “(B) ENFORCEMENT AUTHORITY.—The
23 Secretary is authorized, in connection with con-
24 ducting audits and other activities under sub-
25 section (d), to take such actions, including pur-

1 suit of financial recoveries, necessary to address
2 deficiencies identified in such audits or other
3 activities.”.

4 (2) APPLICATION UNDER PART D.—For provi-
5 sion applying the amendment made by paragraph
6 (1) to prescription drug plans under part D, see sec-
7 tion 1860D–12(b)(3)(D) of the Social Security Act.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall take effect the date of the enactment
10 of this Act and shall apply to audits and activities con-
11 ducted for contract years beginning on or after January
12 1, 2009.

13 **SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAY-**
14 **MENTS.**

15 (a) IN GENERAL.—Not later than 1 year after the
16 date of the enactment of this Act, the Secretary of Health
17 and Human Services shall submit to Congress a report
18 that evaluates the adequacy of the Medicare Advantage
19 risk adjustment system under section 1853(a)(1)(C) of the
20 Social Security Act (42 U.S.C. 1395–23(a)(1)(C)).

21 (b) PARTICULARS.—The report under subsection (a)
22 shall include an evaluation of at least the following:

23 (1) The need and feasibility of improving the
24 adequacy of the risk adjustment system in predicting

1 costs for beneficiaries with co-morbid conditions and
2 associated cognitive impairments.

3 (2) The need and feasibility of including further
4 gradations of diseases and conditions (such as the
5 degree of severity of congestive heart failure).

6 (3) The feasibility of measuring difference in
7 coding over time between Medicare part C plans and
8 the medicare traditional fee-for-service program and,
9 to the extent this difference exists, the options for
10 addressing it.

11 (4) The feasibility and value of including part
12 D and other drug utilization data in the risk adjust-
13 ment model.

14 **SEC. 425. ELIMINATING SPECIAL TREATMENT OF PRIVATE**
15 **FEE-FOR-SERVICE PLANS.**

16 (a) **ELIMINATION OF EXTRA BILLING PROVISION.**—
17 Section 1852(k)(2) of the Social Security Act (42 U.S.C.
18 1395w-22(k)(2)) is amended—

19 (1) in subparagraph (A)(i), by striking “115
20 percent” and inserting “100 percent”; and

21 (2) in subparagraph (C)(i), by striking “ (in-
22 cluding any liability for balance billing consistent
23 with this subsection)”.

(b) REVIEW OF BID INFORMATION.—Section 1854(a)(6)(B) of such Act (42 U.S.C. 1395w-24(a)(6)(B)) is amended—

(1) in clause (i), by striking “clauses (iii) and (iv)” and inserting “clause (iii)”; and

(2) by striking clause (iv).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning with 2009.

SEC. 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—The program under part C of title XVIII of the Social Security Act is henceforth to be known as the “Medicare Part C program”.

(b) CHANGE IN REFERENCES.—

(1) AMENDING SOCIAL SECURITY ACT.—The Social Security Act is amended by striking “Medicare Advantage”, “MA”, and “Medicare+Choice” and inserting “Medicare Part C” each place it appears, with the appropriate, respective typographic formatting, including typeface and capitalization.

(2) ADDITIONAL REFERENCES.—Notwithstanding section 201(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), any reference to the program under part C of title XVIII of the Social Secu-

1 rity Act shall be deemed a reference to the “Medi-
2 care Part C” program and, with respect to such
3 part, any reference to “Medicare+Choice”. “Medi-
4 care Advantage”, or “MA” is deemed a reference to
5 the program under such part.

6 **Subtitle D—Extension of**
7 **Authorities**

8 **SEC. 431. EXTENSION AND REVISION OF AUTHORITY FOR**
9 **SPECIAL NEEDS PLANS (SNPS).**

10 (a) EXTENDING RESTRICTION ON ENROLLMENT AU-
11 THORITY FOR SNPS FOR 3 YEARS.—Subsection (f) of sec-
12 tion 1859 of the Social Security Act (42 U.S.C. 1395w-
13 28) is amended by striking “2009” and inserting “2012”.

14 (b) STRUCTURE OF AUTHORITY FOR SNPS.—

15 (1) IN GENERAL.—Such section is further
16 amended—

17 (A) in subsection (b)(6)(A), by striking all
18 that follows “means” and inserting the fol-
19 lowing: “an MA plan—

20 “(i) that serves special needs individ-
21 uals (as defined in subparagraph (B));

22 “(ii) as of January 1, 2009, either—

23 “(I) at least 90 percent of the
24 enrollees in which are described in
25 subparagraph (B)(i), as determined

1 under regulations in effect as of July
2 1, 2007; or

3 “(II) at least 90 percent of the
4 enrollees in which are described in
5 subparagraph (B)(ii) and are full-ben-
6 efit dual eligible individuals (as de-
7 fined in section 1935(c)(6)) or quali-
8 fied medicare beneficiaries (as defined
9 in section 1905(p)(1)); and

10 “(iii) as of January 1, 2009, meets
11 the applicable requirements of paragraph
12 (2) or (3) of subsection (f), as the case
13 may be.”;

14 (B) in subsection (b)(6)(B)(iii), by insert-
15 ing “only for contract years beginning before
16 January 1, 2009,” after “(iii)”;

17 (C) in subsection (f)—

18 (i) by amending the heading to read
19 as follows: “REQUIREMENTS FOR ENROLL-
20 MENT IN PART C PLANS FOR SPECIAL
21 NEEDS BENEFICIARIES”;

22 (ii) by designating the sentence begin-
23 ning “In the case of” as paragraph (1)
24 with the heading “REQUIREMENTS FOR

1 ENROLLMENT” and with appropriate in-
2 dentation; and

3 (iii) by adding at the end the fol-
4 lowing new paragraphs:

5 “(2) ADDITIONAL REQUIREMENTS FOR INSTI-
6 TUTIONAL SNPS.—In the case of a specialized MA
7 plan for special needs individuals described in sub-
8 section (b)(6)(A)(ii)(I), the applicable requirements
9 of this subsection are as follows:

10 “(A) The plan has an agreement with the
11 State that includes provisions regarding co-
12 operation on the coordination of care for such
13 individuals. Such agreement shall include a de-
14 scription of the manner that the State Medicaid
15 program under title XIX will pay for the costs
16 of services for individuals eligible under such
17 title for medical assistance for acute care and
18 long-term care services.

19 “(B) The plan has a contract with long-
20 term care facilities and other providers in the
21 area sufficient to provide care for enrollees de-
22 scribed in subsection (b)(6)(B)(i).

23 “(C) The plan reports to the Secretary in-
24 formation on additional quality measures speci-

1 fied by the Secretary under section
2 1852(e)(3)(D)(iv)(I) for such plans.

3 “(3) ADDITIONAL REQUIREMENTS FOR DUAL
4 SNPS.—In the case of a specialized MA plan for spe-
5 cial needs individuals described in subsection
6 (b)(6)(A)(ii)(II), the applicable requirements of this
7 subsection are as follows:

8 “(A) The plan has an agreement with the
9 State Medicaid agency that—

10 “(i) includes provisions regarding co-
11 operation on the coordination of the fi-
12 nancing of care for such individuals;

13 “(ii) includes a description of the
14 manner that the State Medicaid program
15 under title XIX will pay for the costs of
16 cost-sharing and supplemental services for
17 individuals enrolled in the plan eligible
18 under such title for medical assistance for
19 acute and long-term care services; and

20 “(iii) effective January 1, 2011, pro-
21 vides for capitation payments to cover
22 costs of supplemental benefits for individ-
23 uals described in subsection
24 (b)(6)(A)(ii)(II).

1 “(B) The out-of-pocket costs for services
2 under parts A and B that are charged to enroll-
3 ees may not exceed the out-of-pocket costs for
4 same services permitted for such individuals
5 under title XIX.

6 “(C) The plan reports to the Secretary in-
7 formation on additional quality measures speci-
8 fied by the Secretary under section
9 1852(e)(3)(D)(iv)(II) for such plans.”.

10 (2) QUALITY STANDARDS AND QUALITY RE-
11 PORTING.—Section 1852(e)(3) of such Act (42
12 U.S.C. 1395w-22(e)(3) is amended—

13 (A) in subparagraph (A)(i), by adding at
14 the end the following: “In the case of a special-
15 ized Medicare Part C plan for special needs in-
16 dividuals described in paragraph (2) or (3) of
17 section 1859(f), the organization shall provide
18 for the reporting on quality measures developed
19 for the plan under subparagraph (D)(iii).”; and

20 (B) in subparagraph (D), as added by sec-
21 tion 422(a)(1), by adding at the end the fol-
22 lowing new clause:

23 “(iii) SPECIFICATION OF ADDITIONAL
24 QUALITY MEASUREMENTS FOR SPECIAL-
25 IZED PART C PLANS.—For implementation

for plan years beginning not later than January 1, 2010, the Secretary shall develop new quality measures appropriate to meeting the needs of—

“(I) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(I)) that serve predominantly individuals who are dual-eligible individuals eligible for medical assistance under title XIX by measuring the special needs for care of individuals who are both Medicare and Medicaid beneficiaries; and

“(II) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(II)) that serve predominantly institutionalized individuals by measuring the special needs for care of individuals who are a resident in long-term care institution.”.

(3) EFFECTIVE DATE; GRANDFATHER.—The amendments made by paragraph (1) shall take effect

1 for enrollments occurring on or after January 1,
2 2009, and shall not apply—

3 (A) to plans with a contract with a State
4 Medicaid agency to operate an integrated Med-
5 icaid-Medicare program, that had been ap-
6 proved by Centers for Medicare & Medicaid
7 Services on January 1, 2004; and

8 (B) to plans that are operational as of the
9 date of the enactment of this Act as approved
10 Medicare demonstration projects and that pro-
11 vide services predominantly to individuals with
12 end-stage renal disease.

13 (4) TRANSITION FOR NON-QUALIFYING SNPS.—

14 (A) RESTRICTIONS IN 2008 FOR CHRONIC
15 CARE SNPS.—In the case of a specialized MA
16 plan for special needs individuals (as defined in
17 section 1859(b)(6)(A) of the Social Security Act
18 (42 U.S.C. 1395w-28(b)(6)(A)) that, as of De-
19 cember 31, 2007, is not described in either sub-
20 clause (I) or subclause (II) of clause (ii) of such
21 section, as amended by paragraph (1), then as
22 of January 1, 2008—

23 (i) the plan may not be offered unless
24 it was offered before such date;

1 (ii) no new members may be enrolled
2 with the plan; and

3 (iii) there may be no expansion of the
4 service area of such plan.

5 (B) TRANSITION OF ENROLLEES.—The
6 Secretary of Health and Human Services shall
7 provide for an orderly transition of those spe-
8 cialized MA plans for special needs individuals
9 (as defined in section 1859(b)(6)(A) of the So-
10 cial Security Act (42 U.S.C. 1395w-
11 28(b)(6)(A)), as of the date of the enactment of
12 this Act), and their enrollees, that no longer
13 qualify as such plans under such section, as
14 amended by this subsection.

15 **SEC. 432. EXTENSION AND REVISION OF AUTHORITY FOR**
16 **MEDICARE REASONABLE COST CONTRACTS.**

17 (a) EXTENSION FOR 3 YEARS OF PERIOD REASON-
18 ABLE COST PLANS CAN REMAIN IN THE MARKET.—Sec-
19 tion 1876(h)(5)(C)(ii) of the Social Security Act (42
20 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter
21 preceding subelause (I), by striking “January 1, 2008”
22 and inserting “January 1, 2011”.

23 (b) APPLICATION OF CERTAIN MEDICARE ADVAN-
24 TAGE REQUIREMENTS TO COST CONTRACTS EXTENDED
25 OR RENEWED AFTER ENACTMENT.—Section 1876(h) of

1 such Act (42 U.S.C. 1395mm(h)), as amended by sub-
2 section (a), is amended—

3 (1) by redesignating paragraph (5) as para-
4 graph (6); and

5 (2) by inserting after paragraph (4) the fol-
6 lowing new paragraph:

7 “(5)(A) Any reasonable cost reimbursement
8 contract with an eligible organization under this sub-
9 section that is extended or renewed on or after the
10 date of enactment of the Children’s Health and
11 Medicare Protection Act of 2007 shall provide that
12 the provisions of the Medicare Part C program de-
13 scribed in subparagraph (B) shall apply to such or-
14 ganization and such contract in a substantially simi-
15 lar manner as such provisions apply to Medicare
16 Part C organizations and Medicare Part C plans
17 under part C.

18 “(B) The provisions described in this sub-
19 paragraph are as follows:

20 “(i) Section 1851(h) (relating to the
21 approval of marketing material and appli-
22 cation forms).

23 “(ii) Section 1852(e) (relating to the
24 requirement of having an ongoing quality
25 improvement program and treatment of ac-

1 creditation in the same manner as such
2 provisions apply to Medicare Part C local
3 plans that are preferred provider organiza-
4 tion plans).

5 “(iii) Section 1852(f) (relating to
6 grievance mechanisms).

7 “(iv) Section 1852(g) (relating to cov-
8 erage determinations, reconsiderations, and
9 appeals).

10 “(v) Section 1852(j)(4) (relating to
11 limitations on physician incentive plans).

12 “(vi) Section 1854(c) (relating to the
13 requirement of uniform premiums among
14 individuals enrolled in the plan).

15 “(vii) Section 1854(g) (relating to re-
16 strictions on imposition of premium taxes
17 with respect to payments to organizations).

18 “(viii) Section 1856(b)(3) (relating to
19 relation to State laws).

20 “(ix) The provisions of part C relating
21 to timelines for contract renewal and bene-
22 ficiary notification.”.

1 TITLE V—PROVISIONS RELAT-
2 ING TO MEDICARE PART A

3 SEC. 501. INPATIENT HOSPITAL PAYMENT UPDATES.

4 (a) FOR ACUTE HOSPITALS.—Clause (i) of section
5 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
6 1395ww(b)(3)(B)) is amended—

7 (1) in subclause (XIX), by striking “and”;

8 (2) by redesignating subclause (XX) as sub-
9 clause (XXII); and

10 (3) by inserting after subclause (XIX) the fol-
11 lowing new subclauses:

12 “(XX) for fiscal year 2007,
13 subject to clause (viii), the mar-
14 ket basket percentage increase
15 for hospitals in all areas,

16 “(XXI) for fiscal year 2008,
17 subject to clause (viii), the mar-
18 ket basket percentage increase
19 minus 0.25 percentage point for
20 hospitals in all areas, and”.

21 (b) FOR OTHER HOSPITALS.—Clause (ii) of such sec-
22 tion is amended—

23 (1) in subclause (VII) by striking “and”;

24 (2) by redesignating subclause (VIII) as sub-
25 clause (X); and

1 (3) by inserting after subclause (VII) the fol-
2 lowing new subclauses:

3 “(VIII) fiscal years 2003
4 through 2007, is the market bas-
5 ket percentage increase,

6 “(IX) fiscal year 2008, is
7 the market basket percentage in-
8 crease minus 0.25 percentage
9 point, and”.

10 (c) DELAYED EFFECTIVE DATE.—

11 (1) ACUTE CARE HOSPITALS.—The amend-
12 ments made by subsection (a) shall not apply to dis-
13 charges occurring before January 1, 2008.

14 (2) OTHER HOSPITALS.—The amendments
15 made by subsection (b) shall be applied, only with
16 respect to cost reporting periods beginning during
17 fiscal year 2008 and not with respect to the com-
18 putation for any succeeding cost reporting period, by
19 substituting “0.1875 percentage point” for “0.25
20 percentage point”.

21 **SEC. 502. PAYMENT FOR INPATIENT REHABILITATION FA-**
22 **CILITY (IRF) SERVICES.**

23 (a) PAYMENT UPDATE.—

24 (1) IN GENERAL.—Section 1886(j)(3)(C) of the
25 Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is

1 amended by adding at the end the following: “The
2 increase factor to be applied under this subpara-
3 graph for fiscal year 2008 shall be 1 percent.”

4 (2) DELAYED EFFECTIVE DATE.—The amend-
5 ment made by paragraph (1) shall not apply to pay-
6 ment units occurring before January 1, 2008.

7 (b) INPATIENT REHABILITATION FACILITY CLASSI-
8 FICATION CRITERIA.—

9 (1) IN GENERAL.—Section 5005 of the Deficit
10 Reduction Act of 2005 (Public Law 109–171) is
11 amended—

12 (A) in subsection (a), by striking “apply
13 the applicable percent specified in subsection
14 (b)” and inserting “require a compliance rate
15 that is no greater than the 60 percent compli-
16 ance rate that became effective for cost report-
17 ing periods beginning on or after July 1,
18 2006,”; and

19 (B) by amending subsection (b) to read as
20 follows:

21 “(b) CONTINUED USE OF COMORBIDITIES.—For por-
22 tions of cost reporting periods occurring on or after the
23 date of the enactment of the Children’s Health and Medi-
24 care Protection Act of 2007, the Secretary shall include
25 patients with comorbidities as described in section

1 412.23(b)(2)(i) of title 42, Code of Federal Regulations
2 (as in effect as of January 1, 2007), in the inpatient popu-
3 lation that counts towards the percent specified in sub-
4 section (a).”.

5 (2) EFFECTIVE DATE.—The amendment made
6 by paragraph (1)(A) shall apply to portions of cost
7 reporting periods beginning on or after the date of
8 the enactment of this Act.

9 (c) PAYMENT FOR CERTAIN MEDICAL CONDITIONS
10 TREATED IN INPATIENT REHABILITATION FACILITIES.—

11 (1) IN GENERAL.—Section 1886(j) of the Social
12 Security Act (42 U.S.C. 1395ww(j)) is amended—

13 (A) by redesignating paragraph (7) as
14 paragraph (8);

15 (B) by inserting after paragraph (6) the
16 following new paragraph:

17 “(7) SPECIAL PAYMENT RULE FOR CERTAIN
18 MEDICAL CONDITIONS.—

19 “(A) IN GENERAL.—Subject to subpara-
20 graph (II), in the case of discharges occurring
21 on or after October 1, 2008, in lieu of the
22 standardized payment amount (as determined
23 pursuant to the preceding provisions of this
24 subsection) that would otherwise be applicable
25 under this subsection, the Secretary shall sub-

stitute, for payment units with respect to an applicable medical condition (as defined in subparagraph (G)(i)) that is treated in an inpatient rehabilitation facility, the modified standardized payment amount determined under subparagraph (B).

“(B) MODIFIED STANDARDIZED PAYMENT AMOUNT.—The modified standardized payment amount for an applicable medical condition shall be based on the amount determined under subparagraph (C) for such condition, as adjusted under subparagraphs (D), (E), and (F).

“(C) AMOUNT DETERMINED.—

“(i) IN GENERAL.—The amount determined under this subparagraph for an applicable medical condition shall be based on the sum of the following:

“(I) An amount equal to the average per stay skilled nursing facility payment rate for the applicable medical condition (as determined under clause (ii)).

“(II) An amount equal to 25 percent of the difference between the overhead costs (as defined in subpara-

graph (G)(ii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the overhead costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

“(III) An amount equal to 33 percent of the difference between the patient care costs (as defined in subparagraph (G)(iii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the patient care costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

“(ii) DETERMINATION OF AVERAGE
PER STAY SKILLED NURSING FACILITY

1 PAYMENT RATE.—For purposes of clause
2 (i), the Secretary shall convert skilled
3 nursing facility payment rates for applica-
4 ble medical conditions, as determined
5 under section 1888(e), to average per stay
6 skilled nursing facility payment rates for
7 each such condition.

8 “(D) ADJUSTMENTS.—The Secretary shall
9 adjust the amount determined under subpara-
10 graph (C) for an applicable medical condition
11 using the adjustments to the prospective pay-
12 ment rates for inpatient rehabilitation facilities
13 described in paragraphs (2), (3), (4), and (6).

14 “(E) UPDATE FOR INFLATION.—Except in
15 the case of a fiscal year for which the Secretary
16 rebases the amounts determined under subpara-
17 graph (C) for applicable medical conditions pur-
18 suant to subparagraph (F), the Secretary shall
19 annually update the amounts determined under
20 subparagraph (C) for each applicable medical
21 condition by the increase factor for inpatient re-
22 habilitation facilities (as described in paragraph
23 (3)(C)).

24 “(F) REBASING.—The Secretary shall pe-
25 riodically (but in no case less than once every

1 5 years) rebase the amounts determined under
2 subparagraph (C) for applicable medical condi-
3 tions using the methodology described in such
4 subparagraph and the most recent and complete
5 cost report and claims data available.

6 “(G) DEFINITIONS.—In this paragraph:

7 “(i) APPLICABLE MEDICAL CONDI-
8 TION.—The term ‘applicable medical condi-
9 tion’ means—

10 “(I) unilateral knee replacement;

11 “(II) unilateral hip replacement;

12 and

13 “(III) unilateral hip fracture.

14 “(ii) OVERHEAD COSTS.—The term
15 ‘overhead costs’ means those Medicare-al-
16 lowable costs that are contained in the
17 General Service cost centers of the Medi-
18 care cost reports for inpatient rehabilita-
19 tion facilities and for skilled nursing facili-
20 ties, respectively, as determined by the
21 Secretary.

22 “(iii) PATIENT CARE COSTS.—The
23 term ‘patient care costs’ means total Medi-
24 care-allowable costs minus overhead costs.

1 “(H) SUNSET.—The provisions of this
2 paragraph shall cease to apply as of the date
3 the Secretary implements an integrated, site-
4 neutral payment methodology under this title
5 for post-acute care.”; and

6 (C) in paragraph (8), as redesignated by
7 paragraph (1)—

8 (i) in subparagraph (C), by striking
9 “and” at the end;

10 (ii) in subparagraph (D), by striking
11 the period at the end and inserting “,
12 and”; and

13 (iii) by adding at the end the fol-
14 lowing new subparagraph:

15 “(E) modified standardized payment
16 amounts under paragraph (7).”.

17 (2) SPECIAL RULE FOR DISCHARGES OCCUR-
18 RING IN THE SECOND HALF OF FISCAL YEAR 2008.—

19 (A) IN GENERAL.—In the case of dis-
20 charges from an inpatient rehabilitation facility
21 occurring during the period beginning on April
22 1, 2008, and ending on September 30, 2008,
23 for applicable medical conditions (as defined in
24 paragraph (7)(G)(i) of section 1886(j) of the
25 Social Security Act (42 U.S.C. 1395ww(j)), as

1 inserted by paragraph (1)(B), in lieu of the
2 standardized payment amount determined pur-
3 suant to such section, the standardized payment
4 amount shall be \$9,507 for unilateral knee re-
5 placement, \$10,398 for unilateral hip replace-
6 ment, and \$10,958 for unilateral hip fracture.
7 Such amounts are the amounts that are esti-
8 mated would be determined under paragraph
9 (7)(C) of such section 1886(j) for such condi-
10 tions if such paragraph applied for such period.
11 Such standardized payment amounts shall be
12 multiplied by the relative weights for each case-
13 mix group and tier, as published in the final
14 rule of the Secretary of Health and Human
15 Services for inpatient rehabilitation facility
16 services prospective payment for fiscal year
17 2008, to obtain the applicable payment
18 amounts for each such condition for each case-
19 mix group and tier.

20 (B) IMPLEMENTATION.—Notwithstanding
21 any other provision of law, the Secretary of
22 Health and Human Services may implement
23 this subsection by program instruction or other-
24 wise. Paragraph (8)(E) of such section 1886(j)
25 of the Social Security Act, as added by para-

1 graph (1)(C), shall apply for purposes of this
2 subsection in the same manner as such para-
3 graph applies for purposes of paragraph (7) of
4 such section 1886(j).

5 (d) RECOMMENDATIONS FOR CLASSIFYING INPA-
6 TIENT REHABILITATION HOSPITALS AND UNITS.—

7 (1) REPORT TO CONGRESS.—Not later than 12
8 months after the date of the enactment of this Act,
9 the Secretary of Health and Human Services, in
10 consultation with physicians (including geriatricians
11 and physiatrists), administrators of inpatient reha-
12 bilitation, acute care hospitals, skilled nursing facili-
13 ties, and other settings providing rehabilitation serv-
14 ices, Medicare beneficiaries, trade organizations rep-
15 resenting inpatient rehabilitation hospitals and units
16 and skilled nursing facilities, and the Medicare Pay-
17 ment Advisory Commission, shall submit to the
18 Committee on Ways and Means of the House of
19 Representatives and the Committee on Finance of
20 the Senate a report that includes—

21 (A) an examination of Medicare bene-
22 ficiaries' access to medically necessary rehabili-
23 tation services;

24 (B) alternatives or refinements to the 75
25 percent rule policy for determining exclusion

1 criteria for inpatient rehabilitation hospital and
2 unit designation under the Medicare program,
3 including determining clinical appropriateness
4 of inpatient rehabilitation hospital and unit ad-
5 missions and alternative criteria which would
6 consider a patient's functional status, diagnosis,
7 co-morbidities, and other relevant factors; and

8 (C) an examination that identifies any con-
9 dition for which individuals are commonly ad-
10 mitted to inpatient rehabilitation hospitals that
11 is not included as a condition described in sec-
12 tion 412.23(b)(2)(iii) of title 42, Code of Fed-
13 eral Regulations, to determine the appropriate
14 setting of care, and any variation in patient
15 outcomes and costs, across settings of care, for
16 treatment of such conditions.

17 For the purposes of this subsection, the term "75
18 percent rule" means the requirement of section
19 412.23(b)(2) of title 42, Code of Federal Regula-
20 tions, that 75 percent of the patients of a rehabilita-
21 tion hospital or converted rehabilitation unit are in
22 1 or more of 13 listed treatment categories.

23 (2) CONSIDERATIONS.—In developing the re-
24 port described in paragraph (1), the Secretary shall
25 include the following:

1 (A) The potential effect of the 75 percent
2 rule on access to rehabilitation care by Medi-
3 care beneficiaries for the treatment of a condi-
4 tion, whether or not such condition is described
5 in section 412.23(b)(2)(iii) of title 42, Code of
6 Federal Regulations.

7 (B) An analysis of the effectiveness of re-
8 habilitation care for the treatment of condi-
9 tions, whether or not such conditions are de-
10 scribed in section 412.23(b)(2)(iii) of title 42,
11 Code of Federal Regulations, available to Medi-
12 care beneficiaries in various health care set-
13 tings, taking into account variation in patient
14 outcomes and costs across different settings of
15 care, and which may include whether the Medi-
16 care program and Medicare beneficiaries may
17 incur higher costs of care for the entire episode
18 of illness due to readmissions, extended lengths
19 of stay, and other factors.

20 **SEC. 503. LONG-TERM CARE HOSPITALS.**

21 (a) LONG-TERM CARE HOSPITAL PAYMENT UP-
22 DATE.—

23 (1) IN GENERAL.—Section 1886 of the Social
24 Security Act (42 U.S.C. 1395ww) is amended by
25 adding at the end the following new subsection:

1 “(m) PROSPECTIVE PAYMENT FOR LONG-TERM
2 CARE HOSPITALS.—

3 “(1) REFERENCE TO ESTABLISHMENT AND IM-
4 PLEMENTATION OF SYSTEM.—For provisions related
5 to the establishment and implementation of a pro-
6 spective payment system for payments under this
7 title for inpatient hospital services furnished by a
8 long-term care hospital described in subsection
9 (d)(1)(B)(iv), see section 123 of the Medicare, Med-
10 icaid, and SCHIP Balanced Budget Refinement Act
11 of 1999 and section 307(b) of Medicare, Medicaid,
12 and SCHIP Benefits Improvement and Protection
13 Act of 2000.

14 “(2) UPDATE FOR RATE YEAR 2008.—In imple-
15 menting the system described in paragraph (1) for
16 discharges occurring during the rate year ending in
17 2008 for a hospital, the base rate for such dis-
18 charges for the hospital shall be the same as the
19 base rate for discharges for the hospital occurring
20 during the previous rate year.”.

21 “(2) DELAYED EFFECTIVE DATE.—Subsection
22 (m)(2) of section 1886 of the Social Security Act, as
23 added by paragraph (1), shall not apply to dis-
24 charges occurring on or after July 1, 2007, and be-
25 fore January 1, 2008.

1 (b) PAYMENT FOR LONG-TERM CARE HOSPITAL
2 SERVICES; PATIENT AND FACILITY CRITERIA.—

3 (1) DEFINITION OF LONG-TERM CARE HOS-
4 PITAL.—

5 (A) DEFINITION.—Section 1861 of the So-
6 cial Security Act (42 U.S.C. 1395x) is amended
7 by adding at the end the following new sub-
8 section:

9 “Long-Term Care Hospital

10 “(ccc) The term ‘long-term care hospital’ means an
11 institution which—

12 “(1) is primarily engaged in providing inpatient
13 services, by or under the supervision of a physician,
14 to Medicare beneficiaries whose medically complex
15 conditions require a long hospital stay and programs
16 of care provided by a long-term care hospital;

17 “(2) has an average inpatient length of stay (as
18 determined by the Secretary) for Medicare bene-
19 ficiaries of greater than 25 days, or as otherwise de-
20 fined in section 1886(d)(1)(B)(iv);

21 “(3) satisfies the requirements of subsection
22 (e);

23 “(4) meets the following facility criteria:

24 “(A) the institution has a patient review
25 process, documented in the patient medical

1 record, that screens patients prior to admission
2 for appropriateness of admission to a long-term
3 care hospital, validates within 48 hours of ad-
4 mission that patients meet admission criteria
5 for long-term care hospitals, regularly evaluates
6 patients throughout their stay for continuation
7 of care in a long-term care hospital, and as-
8 sesses the available discharge options when pa-
9 tients no longer meet such continued stay cri-
10 teria;

11 “(B) the institution has active physician
12 involvement with patients during their treat-
13 ment through an organized medical staff, physi-
14 cian-directed treatment with physician on-site
15 availability on a daily basis to review patient
16 progress, and consulting physicians on call and
17 capable of being at the patient’s side within a
18 moderate period of time, as determined by the
19 Secretary;

20 “(C) the institution has interdisciplinary
21 team treatment for patients, requiring inter-
22 disciplinary teams of health care professionals,
23 including physicians, to prepare and carry out
24 an individualized treatment plan for each pa-
25 tient; and

1 “(5) meets patient criteria relating to patient
2 mix and severity appropriate to the medically com-
3 plex cases that long-term care hospitals are designed
4 to treat, as measured under section 1886(m).”.

5 (B) NEW PATIENT CRITERIA FOR LONG-
6 TERM CARE HOSPITAL PROSPECTIVE PAY-
7 MENT.—Section 1886 of such Act (42 U.S.C.
8 1395ww), as amended by subsection (a), is fur-
9 ther amended by adding at the end the fol-
10 lowing new subsection:

11 “(n) PATIENT CRITERIA FOR PROSPECTIVE PAY-
12 MENT TO LONG-TERM CARE HOSPITALS.—

13 “(1) IN GENERAL.—To be eligible for prospec-
14 tive payment under this section as a long-term care
15 hospital, a long-term care hospital must admit not
16 less than a majority of patients who have a high
17 level of severity, as defined by the Secretary, and
18 who are assigned to one or more of the following
19 major diagnostic categories:

20 “(A) Circulatory diagnoses.

21 “(B) Digestive, endocrine, and metabolic
22 diagnoses.

23 “(C) Infection disease diagnoses.

24 “(D) Neurological diagnoses.

25 “(E) Renal diagnoses.

1 “(F) Respiratory diagnoses.

2 “(G) Skin diagnoses.

3 “(H) Other major diagnostic categories as
4 selected by the Secretary.

5 “(2) MAJOR DIAGNOSTIC CATEGORY DE-
6 FINED.—In paragraph (1), the term ‘major diag-
7 nostic category’ means the medical categories formed
8 by dividing all possible principle diagnosis into mu-
9 tually exclusive diagnosis areas which are referred to
10 in 67 Federal Register 49985 (August 1, 2002).”.

11 (C) ESTABLISHMENT OF REHABILITATION
12 UNITS WITHIN CERTAIN LONG-TERM CARE HOS-
13 PITALS.—If the Secretary of Health and
14 Human Services does not include rehabilitation
15 services within a major diagnostic category
16 under section 1886(n)(2) of the Social Security
17 Act, as added by subparagraph (B), the Sec-
18 retary shall approve for purposes of title XVIII
19 of such Act distinct part inpatient rehabilitation
20 hospital units in long-term care hospitals con-
21 sistent with the following:

22 (i) A hospital that, on or before Octo-
23 ber 1, 2004, was classified by the Sec-
24 retary as a long-term care hospital, as de-
25 scribed in section 1886(d)(1)(B)(iv)(I) of

1 such Act (42 U.S.C.
2 1395ww(d)(1)(V)(iv)(I)), and was accred-
3 ited by the Commission on Accreditation of
4 Rehabilitation Facilities, may establish a
5 hospital rehabilitation unit that is a dis-
6 tinct part of the long-term care hospital, if
7 the distinct part meets the requirements
8 (including conditions of participation) that
9 would otherwise apply to a distinct-part re-
10 habilitation unit if the distinct part were
11 established by a subsection (d) hospital in
12 accordance with the matter following
13 clause (v) of section 1886(d)(1)(B) of such
14 Act, including any regulations adopted by
15 the Secretary in accordance with this sec-
16 tion, except that the one-year waiting pe-
17 riod described in section 412.30(c) of title
18 42, Code of Federal Regulations, applica-
19 ble to the conversion of hospital beds into
20 a distinct-part rehabilitation unit shall not
21 apply to such units.

22 (ii) Services provided in inpatient re-
23 habilitation units established under clause
24 (i) shall not be reimbursed as long-term
25 care hospital services under section 1886

1 of such Act and shall be subject to pay-
2 ment policies established by the Secretary
3 to reimburse services provided by inpatient
4 hospital rehabilitation units.

5 (D) EFFECTIVE DATE.—The amendments
6 made by subparagraphs (A) and (B), and the
7 provisions of subparagraph (C), shall apply to
8 discharges occurring on or after January 1,
9 2008.

10 (2) IMPLEMENTATION OF FACILITY AND PA-
11 TIENT CRITERIA.—

12 (A) REPORT.—No later than 1 year after
13 the date of the enactment of this Act, the Sec-
14 retary of Health and Human Services (in this
15 section referred to as the “Secretary”) shall
16 submit to the appropriate committees of Con-
17 gress a report containing recommendations re-
18 garding the promulgation of the national long-
19 term care hospital facility and patient criteria
20 for application under paragraphs (4) and (5) of
21 section 1861(ccc) and section 1886(n) of the
22 Social Security Act, as added by subparagraphs
23 (A) and (B), respectively, of paragraph (1). In
24 the report, the Secretary shall consider rec-
25 ommendations contained in a report to Con-

gress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term care hospitals are medically complex and appropriate to receive long-term care hospital services.

(B) IMPLEMENTATION.—No later than 1 year after the date of submittal of the report under subparagraph (A), the Secretary shall, after rulemaking, implement the national long-term care hospital facility and patient criteria referred to in such subparagraph. Such long-term care hospital facility and patient criteria shall be used to screen patients in determining the medical necessity and appropriateness of a Medicare beneficiary's admission to, continued stay at, and discharge from, long-term care hospitals under the Medicare program and shall take into account the medical judgment of the patient's physician, as provided for under sections 1814(a)(3) and 1835(a)(2)(B) of the Social Security Act (42 U.S.C. 1395f(a)(3), 1395n(a)(2)(B)).

(3) EXPANDED REVIEW OF MEDICAL NECESSITY.—

1 (A) IN GENERAL.—The Secretary of
2 Health and Human Services shall provide,
3 under contracts with one or more appropriate
4 fiscal intermediaries or medicare administrative
5 contractors under section 1874A(a)(4)(G) of
6 the Social Security Act (42 U.S.C.
7 1395kk(a)(4)(G)), for reviews of the medical
8 necessity of admissions to long-term care hos-
9 pitals (described in section 1886(d)(1)(B)(iv) of
10 such Act) and continued stay at such hospitals,
11 of individuals entitled to, or enrolled for, bene-
12 fits under part A of title XVIII of such Act on
13 a hospital-specific basis consistent with this
14 paragraph. Such reviews shall be made for dis-
15 charges occurring on or after October 1, 2007.

16 (B) REVIEW METHODOLOGY.—The medical
17 necessity reviews under paragraph (A) shall be
18 conducted for each such long-term care hospital
19 on an annual basis in accordance with rules (in-
20 cluding a sample methodology) specified by the
21 Secretary. Such sample methodology shall—

22 (i) provide for a statistically valid and
23 representative sample of admissions of
24 such individuals sufficient to provide re-

1 sults at a 95 percent confidence interval;
2 and

3 (ii) guarantee that at least 75 percent
4 of overpayments received by long-term care
5 hospitals for medically unnecessary admis-
6 sions and continued stays of individuals in
7 long-term care hospitals will be identified
8 and recovered and that related days of care
9 will not be counted toward the length of
10 stay requirement contained in section
11 1886(d)(1)(B)(iv) of the Social Security
12 Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

13 (C) CONTINUATION OF REVIEWS.—Under
14 contracts under this paragraph, the Secretary
15 shall establish a denial rate with respect to such
16 reviews that, if exceeded, could require further
17 review of the medical necessity of admissions
18 and continued stay in the hospital involved.

19 (D) TERMINATION OF REQUIRED RE-
20 VIEWS.—

21 (i) IN GENERAL.—Subject to clause
22 (iii), the previous provisions of this sub-
23 section shall cease to apply as of the date
24 specified in clause (ii).

1 (ii) DATE SPECIFIED.—The date spec-
2 ified in this clause is the later of January
3 1, 2013, or the date of implementation of
4 national long-term care hospital facility
5 and patient criteria under section para-
6 graph (2)(B).

7 (iii) CONTINUATION.—As of the date
8 specified in clause (ii), the Secretary shall
9 determine whether to continue to guar-
10 antee, through continued medical review
11 and sampling under this paragraph, recov-
12 ery of at least 75 percent of overpayments
13 received by long-term care hospitals due to
14 medically unnecessary admissions and con-
15 tinued stays.

16 (4) LIMITED, QUALIFIED MORATORIUM OF
17 LONG-TERM CARE HOSPITALS.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (B), the Secretary shall impose a tem-
20 porary moratorium on the certification of new
21 long-term care hospitals (and satellite facilities),
22 and new long-term care hospital and satellite
23 facility beds, for purposes of the Medicare pro-
24 gram under title XVIII of the Social Security
25 Act. The moratorium shall terminate at the end

1 of the 4-year period beginning on the date of
2 the enactment of this Act.

3 (B) EXCEPTIONS.—

4 (i) IN GENERAL.—The moratorium
5 under subparagraph (A) shall not apply as
6 follows:

7 (I) To a long-term care hospital,
8 satellite facility, or additional beds
9 under development as of the date of
10 the enactment of this Act.

11 (II) To a new long-term care hos-
12 pital in an area in which there is not
13 a long-term care hospital, if the Sec-
14 retary determines it to be in the best
15 interest to provide access to long-term
16 care hospital services to Medicare
17 beneficiaries residing in such area.
18 There shall be a presumption in favor
19 of the moratorium, which may be re-
20 butted by evidence the Secretary
21 deems sufficient to show the need for
22 long-term care hospital services in
23 that area.

24 (III) To an existing long-term
25 care hospital that requests to increase

1 its number of long-term care hospital
2 beds, if the Secretary determines
3 there is a need at the long-term care
4 hospital for additional beds to accom-
5 modate—

6 (aa) infectious disease issues
7 for isolation of patients;

8 (bb) bedside dialysis serv-
9 ices;

10 (cc) single-sex accommoda-
11 tion issues;

12 (dd) behavioral issues;

13 (ee) any requirements of
14 State or local law; or

15 (ff) other clinical issues the
16 Secretary determines warrant ad-
17 ditional beds, in the best interest
18 of Medicare beneficiaries.

19 (IV) To an existing long-term
20 care hospital that requests an increase
21 in beds because of the closure of a
22 long-term care hospital or significant
23 decrease in the number of long-term
24 care hospital beds, in a State where

1 there is only one other long-term care
2 hospital.

3 There shall be no administrative or judicial
4 review from a decision of the Secretary
5 under this subparagraph.

6 (ii) "UNDER DEVELOPMENT" DE-
7 FINED.—For purposes of clause (i)(I), a
8 long-term care hospital or satellite facility
9 is considered to be "under development" as
10 of a date if any of the following have oc-
11 curred on or before such date:

12 (I) The hospital or a related
13 party has a binding written agreement
14 with an outside, unrelated party for
15 the construction, reconstruction, lease,
16 rental, or financing of the long-term
17 care hospital.

18 (II) Actual construction, renova-
19 tion or demolition for the long-term
20 care hospital has begun.

21 (III) A certificate of need has
22 been approved in a State where one is
23 required or other necessary approvals
24 from appropriate State agencies have

1 been received for the operation of the
2 hospital.

3 (IV) The hospital documents that
4 it is within a 6-month long-term care
5 hospital demonstration period re-
6 quired by section 412.23(e)(1)–(3) of
7 title 42, Code of Federal Regulations,
8 to demonstrate that it has a greater
9 than 25 day average length of stay.

10 (V) There is other evidence pre-
11 sented that the Secretary determines
12 would indicate that the hospital or
13 satellite is under development.

14 (5) NO APPLICATION OF 25 PERCENT PATIENT
15 THRESHOLD PAYMENT ADJUSTMENT TO FREE-
16 STANDING AND GRANDFATHERED LTCHS.—The Sec-
17 retary shall not apply, during the 5-year period be-
18 ginning on the date of the enactment of this Act,
19 section 412.536 of title 42, Code of Federal Regula-
20 tions, or any similar provision, to freestanding long-
21 term care hospitals and the Secretary shall not apply
22 such section or section 412.534 of title 42, Code of
23 Federal Regulations, or any similar provisions, to a
24 long-term care hospital identified by section 4417(a)
25 of the Balanced Budget Act of 1997 (Public Law

1 105-33). A long-term care hospital identified by
2 such section 4417(a) shall be deemed to be a free-
3 standing long-term care hospital for the purpose of
4 this section. Section 412.536 of title 42, Code of
5 Federal Regulations, shall be void and of no effect.

6 (6) PAYMENT FOR HOSPITALS-WITHIN-HOS-
7 PITALS.—

8 (A) IN GENERAL.—Payments to an appli-
9 cable long-term care hospital or satellite facility
10 which is located in a rural area or which is co-
11 located with an urban single or MSA dominant
12 hospital under paragraphs (d)(1), (e)(1), and
13 (e)(4) of section 412.534 of title 42, Code of
14 Federal Regulations, shall not be subject to any
15 payment adjustment under such section if no
16 more than 75 percent of the hospital's Medicare
17 discharges (other than discharges described in
18 paragraphs (d)(2) or (e)(3) of such section) are
19 admitted from a co-located hospital.

20 (B) CO-LOCATED LONG-TERM CARE HOS-
21 PITALS AND SATELLITE FACILITIES.—

22 (i) IN GENERAL.—Payment to an ap-
23 plicable long-term care hospital or satellite
24 facility which is co-located with another
25 hospital shall not be subject to any pay-

1 ment adjustment under section 412.534 of
2 title 42, Code of Federal Regulations, if no
3 more than 50 percent of the hospital's
4 Medicare discharges (other than discharges
5 described in section 412.534(c)(3) of such
6 title) are admitted from a co-located hos-
7 pital.

8 (ii) APPLICABLE LONG-TERM CARE
9 HOSPITAL OR SATELLITE FACILITY DE-
10 FINED.—In this paragraph, the term “ap-
11 plicable long-term care hospital or satellite
12 facility” means a hospital or satellite facil-
13 ity that is subject to the transition rules
14 under section 412.534(g) of title 42, Code
15 of Federal Regulations.

16 (C) EFFECTIVE DATE.—Subparagraphs
17 (A) and (B) shall apply to discharges occurring
18 on or after October 1, 2007, and before October
19 1, 2012.

20 (7) NO APPLICATION OF VERY SHORT-STAY
21 OUTLIER POLICY.—The Secretary shall not apply,
22 during the 5-year period beginning on the date of
23 the enactment of this Act, the amendments finalized
24 on May 11, 2007 (72 Federal Register 26904) made
25 to the short-stay outlier payment provision for long-

1 term care hospitals contained in section
2 412.529(e)(3)(i) of title 42, Code of Federal Regula-
3 tions, or any similar provision.

4 (8) NO APPLICATION OF ONE TIME ADJUST-
5 MENT TO STANDARD AMOUNT.—The Secretary shall
6 not, during the 5-year period beginning on the date
7 of the enactment of this Act, make the one-time pro-
8 spective adjustment to long-term care hospital pro-
9 spective payment rates provided for in section
10 412.523(d)(3) of title 42, Code of Federal Regula-
11 tions, or any similar provision.

12 (c) SEPARATE CLASSIFICATION FOR CERTAIN LONG-
13 STAY CANCER HOSPITALS.—

14 (1) IN GENERAL.—Subsection (d)(1)(B) of sec-
15 tion 1886 of the Social Security Act (42 U.S.C.
16 1395ww) is amended—

17 (A) in clause (iv)—

18 (i) in subclause (I), by striking
19 “(iv)(I)” and inserting “(iv)” and by strik-
20 ing “or” at the end; and

21 (ii) in subclause (II)—

22 (I) by striking “, or” at the end
23 and inserting a semicolon; and

1 (II) by redesignating such sub-
2 clause as clause (vi) and by moving it
3 to immediately follow clause (v); and
4 (B) in clause (v), by striking the semicolon
5 at the end and inserting “, or”.

6 (2) CONFORMING PAYMENT REFERENCES.—

7 Subsection (b) of such section is amended—

8 (A) in paragraph (2)(E)(ii), by adding at
9 the end the following new subclause:

10 “(III) Hospitals described in
11 clause (vi) of such subsection.”;

12 (B) in paragraph (3)(F)(iii), by adding at
13 the end the following new subclause:

14 “(VI) Hospitals described in
15 clause (vi) of such subsection.”;

16 (C) in paragraphs (3)(G)(ii), (3)(H)(i),
17 and (3)(H)(ii)(I), by inserting “or (vi)” after
18 “clause (iv)” each place it appears;

19 (D) in paragraph (3)(H)(iv), by adding at
20 the end the following new subclause:

21 “(IV) Hospitals described in
22 clause (vi) of such subsection.”;

23 (E) in paragraph (3)(J), by striking “sub-
24 section (d)(1)(B)(iv)” and inserting “clause (iv)
25 or (vi) of subsection (d)(1)(B)”;

1 (F) in paragraph (7)(B), by adding at the
2 end the following new clause:

3 “(iv) Hospitals described in clause (vi)
4 of such subsection.”.

5 (3) ADDITIONAL CONFORMING AMENDMENTS.—

6 The second sentence of subsection (d)(1)(B) of such
7 section is amended—

8 (A) by inserting “(as in effect as of such
9 date)” after “clause (iv)”; and

10 (B) by inserting “(or, in the case of a hos-
11 pital classified under clause (iv)(II), as so in ef-
12 fect, shall be classified under clause (vi) on and
13 after the effective date of such clause)” after
14 “so classified”.

15 (4) TRANSITION RULE.—In the case of a hos-
16 pital that is classified under clause (iv)(II) of section
17 1886(d)(1)(B) of the Social Security Act imme-
18 diately before the date of the enactment of this Act
19 and which is classified under clause (vi) of such sec-
20 tion after such date of enactment, payments under
21 section 1886 of such Act for cost reporting periods
22 beginning after the date of the enactment of this Act
23 shall be based upon payment rates in effect for the
24 cost reporting period for such hospital beginning
25 during fiscal year 2001, increased for each suc-

ceeding cost reporting period (beginning before the date of the enactment of this Act) by the applicable percentage increase under section 1886(b)(3)(B)(ii) of such Act.

(5) CLARIFICATION OF TREATMENT OF SATELLITE FACILITIES AND REMOTE LOCATIONS.—A long-stay cancer hospital described in section 1886(d)(1)(B)(vi) of the Social Security Act, as designated under paragraph (1), shall include satellites or remote site locations for such hospital established before or after the date of the enactment of this Act if the provider-based requirements under section 413.65 of title 42, Code of Federal Regulations, applicable certification requirements under title XVIII of the Social Security, and such other applicable State licensure and certificate of need requirements are met with respect to such satellites or remote site locations.

SEC. 504. INCREASING THE DSH ADJUSTMENT CAP.

Section 1886(d)(5)(F)(xiv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(xiv)) is amended—

(1) subclause (II), by striking “12 percent” and inserting “the percent specified in subclause (III)”;

and

1 (2) by adding at the end the following new sub-
2 clause:

3 “(III) The percent specified in this subclause is,
4 in the case of discharges occurring—

5 “(a) before October 1, 2007, 12 percent;

6 “(b) during fiscal year 2008, 16 percent;

7 “(c) during fiscal year 2009, 18 percent;

8 and

9 “(d) on or after October 1, 2009, 12 per-
10 cent.”.

11 **SEC. 505. PPS-EXEMPT CANCER HOSPITALS.**

12 (a) AUTHORIZING REBASING FOR PPS-EXEMPT
13 CANCER HOSPITALS.—Section 1886(b)(3)(F) of the So-
14 cial Security Act (42 U.S.C. 1395ww(b)(3)(F)) is amend-
15 ed by adding at the end the following new clause:

16 “(iv) In the case of a hospital (or unit
17 described in the matter following clause (v)
18 of subsection (d)(1)(B)) that received pay-
19 ment under this subsection for inpatient
20 hospital services furnished during cost re-
21 porting periods beginning before October
22 1, 1999, that is within a class of hospital
23 described in clause (iii) (other than sub-
24 clause (IV), relating to long-term care hos-
25 pitals, and that requests the Secretary (in

1 a form and manner specified by the Sec-
2 retary) to effect a rebasing under this
3 clause for the hospital, the Secretary may
4 compute the target amount for the hos-
5 pital's 12-month cost reporting period be-
6 ginning during fiscal year 2008 as an
7 amount equal to the average described in
8 clause (ii) but determined as if any ref-
9 erence in such clause to 'the date of the
10 enactment of this subparagraph' were a
11 reference to 'the date of the enactment of
12 this clause'.

13 (b) MEDPAC REPORT ON PPS-EXEMPT CANCER
14 HOSPITALS.—Not later than March 1, 2009, the Medicare
15 Payment Advisory Commission (established under section
16 1805 of the Social Security Act (42 U.S.C. 1395b-6)) shall
17 submit to the Secretary and Congress a report evaluating
18 the following:

19 (1) Measures of payment adequacy and Medi-
20 care margins for PPS-exempt cancer hospitals, as
21 established under section 1886(d)(1)(B)(v) of the
22 Social Security Act (42 U.S.C.
23 1395ww(d)(1)(B)(v)).

24 (2) To the extent a PPS-exempt cancer hospital
25 was previously affiliated with another hospital, the

1 margins of the PPS-exempt hospital and the other
2 hospital as separate entities and the margins of such
3 hospitals that existed when the hospitals were pre-
4 viously affiliated.

5 (3) Payment adequacy for cancer discharges
6 under the Medicare inpatient hospital prospective
7 payment system.

8 **SEC. 506. SKILLED NURSING FACILITY PAYMENT UPDATE.**

9 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the
10 Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is
11 amended—

12 (1) in subclause (III), by striking “and”;

13 (2) by redesignating subsection (IV) as sub-
14 clause (VI); and

15 (3) by inserting after subclause (III) the fol-
16 lowing new subclauses:

17 “(IV) for each of fiscal years
18 2004, 2005, 2006, and 2007, the rate
19 computed for the previous fiscal year
20 increased by the skilled nursing facil-
21 ity market basket percentage change
22 for the fiscal year involved;

23 “(V) for fiscal year 2008, the
24 rate computed for the previous fiscal
25 year; and”.

(b) DELAYED EFFECTIVE DATE.—Section 1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted by subsection (a)(3), shall not apply to payment for days before January 1, 2008.

SEC. 507. REVOCATION OF UNIQUE DEEMING AUTHORITY OF THE JOINT COMMISSION FOR THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS.

(a) REVOCATION.—Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended—

(1) by striking subsection (a); and
(2) by redesignating subsections (b), (c), (d), and (e) as subsections (a), (b), (c), and (d), respectively.

(b) CONFORMING AMENDMENTS.—(1) Such section is further amended—

(A) in subsection (a)(1), as so redesignated, by striking “In addition, if” and inserting “If”;

(B) in subsection (b), as so redesignated—

(i) by striking “released to him by the Joint Commission on Accreditation of Hospitals,” and inserting “released to the Secretary by”; and

1 (ii) by striking the comma after “As-
2 sociation”;

3 (C) in subsection (c), as so redesignated,
4 by striking “pursuant to subsection (a) or
5 (b)(1)” and inserting “pursuant to subsection
6 (a)(1)”; and

7 (D) in subsection (d), as so redesignated,
8 by striking “pursuant to subsection (a) or
9 (b)(1)” and inserting “pursuant to subsection
10 (a)(1)”.

11 (2) Section 1861(e) of such Act (42 U.S.C.
12 1395x(e)) is amended in the fourth sentence by
13 striking “and (ii) is accredited by the Joint Commis-
14 sion on Accreditation of Hospitals, or is accredited
15 by or approved by a program of the country in which
16 such institution is located if the Secretary finds the
17 accreditation or comparable approval standards of
18 such program to be essentially equivalent to those of
19 the Joint Commission on Accreditation of Hospitals”
20 and inserting “and (ii) is accredited by a national
21 accreditation body recognized by the Secretary under
22 section 1865(a), or is accredited by or approved by
23 a program of the country in which such institution
24 is located if the Secretary finds the accreditation or
25 comparable approval standards of such program to

1 be essentially equivalent to those of such a national
2 accreditation body.”.

3 (3) Section 1864(c) of such Act (42 U.S.C.
4 1395aa(c)) is amended by striking “pursuant to sub-
5 section (a) or (b)(1) of section 1865” and inserting
6 “pursuant to section 1865(a)(1)”.

7 (4) Section 1875(b) of such Act (42 U.S.C.
8 1395ll(b)) is amended by striking “the Joint Com-
9 mission on Accreditation of Hospitals,” and insert-
10 ing “national accreditation bodies under section
11 1865(a)”.

12 (5) Section 1834(a)(20)(B) of such Act (42
13 U.S.C. 1395m(a)(20)(B)) is amended by striking
14 “section 1865(b)” and inserting “section 1865(a)”.

15 (6) Section 1852(e)(4)(C) of such Act (42
16 U.S.C. 1395w-22(e)(4)(C)) is amended by striking
17 “section 1865(b)(2)” and inserting “section
18 1865(a)(2)”.

19 (c) AUTHORITY TO RECOGNIZE JCAHO AS A NA-
20 TIONAL ACCREDITATION BODY.—The Secretary of Health
21 and Human Services may recognize the Joint Commission
22 on Accreditation of Healthcare Organizations as a na-
23 tional accreditation body under section 1865 of the Social
24 Security Act (42 U.S.C. 1395bb), as amended by this sec-

tion, upon such terms and conditions, and upon submission of such information, as the Secretary may require.

(d) EFFECTIVE DATE; TRANSITION RULE.—(1) Subject to paragraph (2), the amendments made by this section shall apply with respect to accreditations of hospitals granted on or after the date that is 18 months after the date of the enactment of this Act.

(2) For purposes of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the amendments made by this section shall not effect the accreditation of a hospital by the Joint Commission on Accreditation of Healthcare Organizations, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission on Accreditation of Healthcare Organizations, for the period of time applicable under such accreditation.

TITLE VI—OTHER PROVISIONS RELATING TO MEDICARE PART B

Subtitle A—Payment and Coverage Improvements

SEC. 601. PAYMENT FOR THERAPY SERVICES.

(a) EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.—Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended

1 by section 201 of the Medicare Improvements and Extension
2 Act of 2006 (division B of Public Law 109-432), is
3 amended by striking “2007” and inserting “2009”.

4 (b) STUDY AND REPORT.—

5 (1) STUDY.—The Secretary of Health and
6 Human Services, in consultation with appropriate
7 stakeholders, shall conduct a study on refined and
8 alternative payment systems to the Medicare pay-
9 ment cap under section 1833(g) of the Social Security
10 Act (42 U.S.C. 1395l(g)) for physical therapy
11 services and speech-language pathology services, de-
12 scribed in paragraph (1) of such section and occupa-
13 tional therapy services described in paragraph (3) of
14 such section. Such study shall consider, with respect
15 to payment amounts under Medicare, the following:

16 (A) The creation of multiple payment caps
17 for such services to better reflect costs associ-
18 ated with specific health conditions.

19 (B) The development of a prospective pay-
20 ment system, including an episode-based system
21 of payments, for such services.

22 (C) The data needed for the development
23 of a system of multiple payment caps (or an al-
24 ternative payment methodology) for such serv-
25 ices and the availability of such data.

1 (2) REPORT.—Not later than January 1, 2009,
2 the Secretary shall submit to Congress a report on
3 the study conducted under paragraph (1).

4 **SEC. 602. MEDICARE SEPARATE DEFINITION OF OUT-**
5 **PATIENT SPEECH-LANGUAGE PATHOLOGY**
6 **SERVICES.**

7 (a) IN GENERAL.—Section 1861(l) of the Social Se-
8 curity Act (42 U.S.C. 1395x(l)) is amended—

9 (1) by redesignating paragraphs (2) and (3) as
10 paragraphs (3) and (4), respectively; and

11 (2) by inserting after paragraph (1) the fol-
12 lowing new paragraph:

13 “(2) The term ‘outpatient speech-language pa-
14 thology services’ has the meaning given the term
15 ‘outpatient physical therapy services’ in subsection
16 (p), except that in applying such subsection—

17 “(A) ‘speech-language pathology’ shall be
18 substituted for ‘physical therapy’ each place it
19 appears; and

20 “(B) ‘speech-language pathologist’ shall be
21 substituted for ‘physical therapist’ each place it
22 appears.”.

23 (b) CONFORMING AMENDMENTS.—

24 (1) Section 1832(a)(2)(C) of the Social Security
25 Act (42 U.S.C. 1395k(a)(2)(C)) is amended—

1 (A) by striking “and outpatient” and in-
2 serting “, outpatient”; and

3 (B) by inserting before the period at the
4 end the following: “, and outpatient speech-lan-
5 guage pathology services (other than services to
6 which the second sentence of section 1861(p)
7 applies through the application of section
8 1861(ll)(2))”.

9 (2) Subparagraphs (A) and (B) of section
10 1833(a)(8) of such Act (42 U.S.C. 1395l(a)(8)) are
11 each amended by striking “(which includes out-
12 patient speech-language pathology services)” and in-
13 serting “, outpatient speech-language pathology
14 services,”.

15 (3) Section 1833(g)(1) of such Act (42 U.S.C.
16 1395l(g)(1)) is amended—

17 (A) by inserting “and speech-language pa-
18 thology services of the type described in such
19 section through the application of section
20 1861(ll)(2)” after “1861(p)”; and

21 (B) by inserting “and speech-language pa-
22 thology services” after “and physical therapy
23 services”.

24 (4) The second sentence of section 1835(a) of
25 such Act (42 U.S.C. 1395n(a)) is amended—

1 (A) by striking “section 1861(g)” and in-
2 serting “subsection (g) or (ll)(2) of section
3 1861” each place it appears; and

4 (B) by inserting “or outpatient speech-lan-
5 guage pathology services, respectively” after
6 “occupational therapy services”.

7 (5) Section 1861(p) of such Act (42 U.S.C.
8 1395x(p)) is amended by striking the fourth sen-
9 tence.

10 (6) Section 1861(s)(2)(D) of such Act (42
11 U.S.C. 1395x(s)(2)(D)) is amended by inserting “,
12 outpatient speech-language pathology services,” after
13 “physical therapy services”.

14 (7) Section 1862(a)(20) of such Act (42 U.S.C.
15 1395y(a)(20)) is amended—

16 (A) by striking “outpatient occupational
17 therapy services or outpatient physical therapy
18 services” and inserting “outpatient physical
19 therapy services, outpatient speech-language pa-
20 thology services, or outpatient occupational
21 therapy services”; and

22 (B) by striking “section 1861(g)” and in-
23 serting “subsection (g) or (ll)(2) of section
24 1861”.

1 (8) Section 1866(e)(1) of such Act (42 U.S.C.
2 1395ee(e)(1)) is amended—

3 (A) by striking “section 1861(g)” and in-
4 serting “subsection (g) or (ll)(2) of section
5 1861” the first two places it appears;

6 (B) by striking “defined) or” and inserting
7 “defined),”; and

8 (C) by inserting before the semicolon at
9 the end the following: “, or (through the oper-
10 ation of section 1861(ll)(2)) with respect to the
11 furnishing of outpatient speech-language pa-
12 thology”.

13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to services furnished on or after
15 January 1, 2008.

16 (d) CONSTRUCTION.—Nothing in this section shall be
17 construed to affect existing regulations and policies of the
18 Centers for Medicare & Medicaid Services that require
19 physician oversight of care as a condition of payment for
20 speech-language pathology services under part B of the
21 medicare program.

22 **SEC. 603. INCREASED REIMBURSEMENT RATE FOR CER-**
23 **TIFIED NURSE-MIDWIVES.**

24 (a) IN GENERAL.—Section 1833(a)(1)(K) of the So-
25 cial Security Act (42 U.S.C.1395l(a)(1)(K)) is amended

1 by striking “(but in no event” and all that follows through
2 “performed by a physician)”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to services furnished on or after
5 April 1, 2008.

6 **SEC. 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE**
7 **SCHEDULE INCREASE FACTOR.**

8 The first sentence of section 1833(t)(3)(C)(iv) of the
9 Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is
10 amended by inserting before the period at the end the fol-
11 lowing: “and reduced by 0.25 percentage point for such
12 factor for such services furnished in 2008”.

13 **SEC. 605. EXCEPTION TO 60-DAY LIMIT ON MEDICARE SUB-**
14 **STITUTE BILLING ARRANGEMENTS IN CASE**
15 **OF PHYSICIANS ORDERED TO ACTIVE DUTY**
16 **IN THE ARMED FORCES.**

17 (a) IN GENERAL.—Section 1842(b)(6)(D)(iii) of the
18 Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)) is
19 amended by inserting after “of more than 60 days” the
20 following: “or are provided over a longer continuous period
21 during all of which the first physician has been called or
22 ordered to active duty as a member of a reserve component
23 of the Armed Forces”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to services furnished on or after
3 the date of the enactment of this section.

4 **SEC. 606. EXCLUDING CLINICAL SOCIAL WORKER SERVICES**
5 **FROM COVERAGE UNDER THE MEDICARE**
6 **SKILLED NURSING FACILITY PROSPECTIVE**
7 **PAYMENT SYSTEM AND CONSOLIDATED PAY-**
8 **MENT.**

9 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the
10 Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is
11 amended by inserting “clinical social worker services,”
12 after “qualified psychologist services,”..

13 (b) CONFORMING AMENDMENT.—Section
14 1861(hh)(2) of the Social Security Act (42 U.S.C.
15 1395x(hh)(2)) is amended by striking “and other than
16 services furnished to an inpatient of a skilled nursing facil-
17 ity which the facility is required to provide as a require-
18 ment for participation”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to items and services furnished on
21 or after January 1, 2008.

1 **SEC. 607. COVERAGE OF MARRIAGE AND FAMILY THERA-**
2 **PIST SERVICES AND MENTAL HEALTH COUN-**
3 **SELOR SERVICES.**

4 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-
5 PIST SERVICES.—

6 (1) COVERAGE OF SERVICES.—Section
7 1861(s)(2) of the Social Security Act (42 U.S.C.
8 1395x(s)(2)) is amended—

9 (A) in subparagraph (Z), by striking
10 “and” at the end;

11 (B) in subparagraph (AA), by adding
12 “and” at the end; and

13 (C) by adding at the end the following new
14 subparagraph:

15 “(BB) marriage and family therapist services
16 (as defined in subsection (ccc));”.

17 (2) DEFINITION.—Section 1861 of the Social
18 Security Act (42 U.S.C. 1395x) is amended by add-
19 ing at the end the following new subsection:

20 “(ccc) MARRIAGE AND FAMILY THERAPIST SERV-
21 ICES.—(1) The term ‘marriage and family therapist serv-
22 ices’ means services performed by a marriage and family
23 therapist (as defined in paragraph (2)) for the diagnosis
24 and treatment of mental illnesses, which the marriage and
25 family therapist is legally authorized to perform under
26 State law (or the State regulatory mechanism provided by

1 State law) of the State in which such services are per-
2 formed, provided such services are covered under this title,
3 as would otherwise be covered if furnished by a physician
4 or as incident to a physician's professional service, but
5 only if no facility or other provider charges or is paid any
6 amounts with respect to the furnishing of such services.

7 “(2) The term ‘marriage and family therapist’ means
8 an individual who—

9 “(A) possesses a master's or doctoral degree
10 which qualifies for licensure or certification as a
11 marriage and family therapist pursuant to State
12 law;

13 “(B) after obtaining such degree has performed
14 at least 2 years of clinical supervised experience in
15 marriage and family therapy; and

16 “(C) is licensed or certified as a marriage and
17 family therapist in the State in which marriage and
18 family therapist services are performed.”.

19 (3) PROVISION FOR PAYMENT UNDER PART
20 b.—Section 1832(a)(2)(B) of the Social Security Act
21 (42 U.S.C. 1395k(a)(2)(B)) is amended by adding
22 at the end the following new clause:

23 “(v) marriage and family therapist
24 services;”.

25 (4) AMOUNT OF PAYMENT.—

1 (A) IN GENERAL.—Section 1833(a)(1) of
2 the Social Security Act (42 U.S.C. 1395l(a)(1))
3 is amended—

4 (i) by striking “and” before “(V)”;
5 and

6 (ii) by inserting before the semicolon
7 at the end the following: “, and (W) with
8 respect to marriage and family therapist
9 services under section 1861(s)(2)(BB), the
10 amounts paid shall be 80 percent of the
11 lesser of (i) the actual charge for the serv-
12 ices or (ii) 75 percent of the amount deter-
13 mined for payment of a psychologist under
14 subparagraph (L)”.

15 (B) DEVELOPMENT OF CRITERIA WITH RE-
16 SPECT TO CONSULTATION WITH A PHYSICIAN.—

17 The Secretary of Health and Human Services
18 shall, taking into consideration concerns for pa-
19 tient confidentiality, develop criteria with re-
20 spect to payment for marriage and family ther-
21 apist services for which payment may be made
22 directly to the marriage and family therapist
23 under part B of title XVIII of the Social Secu-
24 rity Act (42 U.S.C. 1395j et seq.) under which
25 such a therapist must agree to consult with a

1 patient's attending or primary care physician in
2 accordance with such criteria.

3 (5) EXCLUSION OF MARRIAGE AND FAMILY
4 THERAPIST SERVICES FROM SKILLED NURSING FA-
5 CILITY PROSPECTIVE PAYMENT SYSTEM.—Section
6 1888(e)(2)(A)(ii) of the Social Security Act (42
7 U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting
8 “marriage and family therapist services (as defined
9 in subsection (ccc)(1)),” after “qualified psychologist
10 services,”.

11 (6) COVERAGE OF MARRIAGE AND FAMILY
12 THERAPIST SERVICES PROVIDED IN RURAL HEALTH
13 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
14 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
15 rity Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by
16 striking “or by a clinical social worker (as defined
17 in subsection (hh)(1)),” and inserting “, by a clinical
18 social worker (as defined in subsection (hh)(1)), or
19 by a marriage and family therapist (as defined in
20 subsection (ccc)(2)),”.

21 (7) INCLUSION OF MARRIAGE AND FAMILY
22 THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT
23 OF CLAIMS.—Section 1842(b)(18)(C) of the Social
24 Security Act (42 U.S.C. 1395u(b)(18)(C)) is amend-
25 ed by adding at the end the following new clause:

1 “(vii) A marriage and family therapist (as de-
2 fined in section 1861(eee)(2)).”.

3 (b) COVERAGE OF MENTAL HEALTH COUNSELOR
4 SERVICES.—

5 (1) COVERAGE OF SERVICES.—Section
6 1861(s)(2) of the Social Security Act (42 U.S.C.
7 1395x(s)(2)), as amended in subsection (a)(1), is
8 further amended—

9 (A) in subparagraph (AA), by striking
10 “and” at the end;

11 (B) in subparagraph (BB), by inserting
12 “and” at the end; and

13 (C) by adding at the end the following new
14 subparagraph:

15 “(CC) mental health counselor services (as
16 defined in subsection (ddd)(2));”.

17 (2) DEFINITION.—Section 1861 of the Social
18 Security Act (42 U.S.C. 1395x), as amended by sub-
19 section (a)(2), is further amended by adding at the
20 end the following new subsection:

21 “(ddd) MENTAL HEALTH COUNSELOR; MENTAL
22 HEALTH COUNSELOR SERVICES.—(1) The term ‘mental
23 health counselor’ means an individual who—

24 “(A) possesses a master’s or doctor’s degree
25 which qualifies the individual for licensure or certifi-

1 education for the practice of mental health counseling in
2 the State in which the services are performed;

3 “(B) after obtaining such a degree has per-
4 formed at least 2 years of supervised mental health
5 counselor practice; and

6 “(C) is licensed or certified as a mental health
7 counselor or professional counselor by the State in
8 which the services are performed.

9 “(2) The term ‘mental health counselor services’
10 means services performed by a mental health counselor (as
11 defined in paragraph (1)) for the diagnosis and treatment
12 of mental illnesses which the mental health counselor is
13 legally authorized to perform under State law (or the
14 State regulatory mechanism provided by the State law) of
15 the State in which such services are performed, provided
16 such services are covered under this title, as would other-
17 wise be covered if furnished by a physician or as incident
18 to a physician’s professional service, but only if no facility
19 or other provider charges or is paid any amounts with re-
20 spect to the furnishing of such services.”.

21 (3) PROVISION FOR PAYMENT UNDER PART
22 b.—Section 1832(a)(2)(B) of the Social Security Act
23 (42 U.S.C. 1395k(a)(2)(B)), as amended by sub-
24 section (a)(3), is further amended by adding at the
25 end the following new clause:

1 “(vi) mental health counselor serv-
2 ices;”.

3 (4) AMOUNT OF PAYMENT.—

4 (A) IN GENERAL.—Section 1833(a)(1) of
5 the Social Security Act (42 U.S.C.
6 1395l(a)(1)), as amended by subsection (a)(4),
7 is further amended—

8 (i) by striking “and” before “(W)”;
9 and

10 (ii) by inserting before the semicolon
11 at the end the following: “, and (X) with
12 respect to mental health counselor services
13 under section 1861(s)(2)(CC), the amounts
14 paid shall be 80 percent of the lesser of (i)
15 the actual charge for the services or (ii) 75
16 percent of the amount determined for pay-
17 ment of a psychologist under subparagraph
18 (I)”.

19 (B) DEVELOPMENT OF CRITERIA WITH RE-
20 SPECT TO CONSULTATION WITH A PHYSICIAN.—

21 The Secretary of Health and Human Services
22 shall, taking into consideration concerns for pa-
23 tient confidentiality, develop criteria with re-
24 spect to payment for mental health counselor
25 services for which payment may be made di-

1 rectly to the mental health counselor under part
2 B of title XVIII of the Social Security Act (42
3 U.S.C. 1395j et seq.) under which such a coun-
4 selor must agree to consult with a patient's at-
5 tending or primary care physician in accordance
6 with such criteria.

7 (5) EXCLUSION OF MENTAL HEALTH COUN-
8 SELOR SERVICES FROM SKILLED NURSING FACILITY
9 PROSPECTIVE PAYMENT SYSTEM.—Section
10 1888(e)(2)(A)(ii) of the Social Security Act (42
11 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by sub-
12 section (a)(5), is amended by inserting “mental
13 health counselor services (as defined in section
14 1861(ddd)(2)),” after “marriage and family thera-
15 pist services (as defined in subsection (ccc)(1)),”.

16 (6) COVERAGE OF MENTAL HEALTH COUN-
17 SELOR SERVICES PROVIDED IN RURAL HEALTH
18 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
19 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
20 rity Act (42 U.S.C. 1395x(aa)(1)(B)), as amended
21 by subsection (a)(6), is amended by striking “or by
22 a marriage and family therapist (as defined in sub-
23 section (ccc)(2)),” and inserting “by a marriage and
24 family therapist (as defined in subsection (ccc)(2)),

1 or a mental health counselor (as defined in sub-
2 section (ddd)(1)),”.

3 (7) INCLUSION OF MENTAL HEALTH COUN-
4 SELORS AS PRACTITIONERS FOR ASSIGNMENT OF
5 CLAIMS.—Section 1842(b)(18)(C) of the Social Se-
6 curity Act (42 U.S.C. 1395u(b)(18)(C)), as amended
7 by subsection (a)(7), is amended by adding at the
8 end the following new clause:

9 “(viii) A mental health counselor (as defined in
10 section 1861(fff)(1)).”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to items and services furnished on
13 or after January 1, 2008.

14 **SEC. 608. RENTAL AND PURCHASE OF POWER-DRIVEN**
15 **WHEELCHAIRS.**

16 (a) IN GENERAL.—Section 1834(a)(7) of the Social
17 Security Act (42 U.S.C. 1395m(a)(7)) is amended—

18 (1) in subparagraph (A)—

19 (A) clause (i)(I), by striking “Except as
20 provided in clause (iii), payment” and inserting
21 “Payment”;

22 (B) by striking clause (iii); and

23 (C) in clause (iv)—

24 (i) by redesignating such clause as
25 clause (iii); and

1 (ii) by striking “or in the case of a
2 power-driven wheelchair for which a pur-
3 chase agreement has been entered into
4 under clause (iii)”; and

5 (2) in subparagraph (C)(ii)(II), by striking “or
6 (A)(iii)”.

7 (b) EFFECTIVE DATE.—

8 (1) IN GENERAL.—Subject to paragraph (1),
9 the amendments made by subsection (a) shall take
10 effect on January 1, 2008, and shall apply to power-
11 driven wheelchairs furnished on or after such date.

12 (2) APPLICATION TO COMPETITIVE ACQUI-
13 SITION.—The amendments made by subsection (a)
14 shall not apply to contracts entered into under sec-
15 tion 1847 of the Social Security Act (42 U.S.C.
16 1395w–3) pursuant to a bid submitted under such
17 section before July 21, 2007.

18 **SEC. 609. RENTAL AND PURCHASE OF OXYGEN EQUIPMENT.**

19 (a) IN GENERAL.—Section 1834(a)(5)(F) of the So-
20 cial Security Act (42 U.S.C. 1395m(a)(5)(F)) is amend-
21 ed—

22 (1) in clause (i)—

23 (A) by striking “Payment” and inserting
24 “Subject to clause (iii), payment”; and

1 (B) by striking “36 months” and inserting
2 “13 months”;

3 (2) in clause (ii)(I), by striking “36th contin-
4 uous month” and inserting “13th continuous
5 month”; and

6 (3) by adding at the end the following new
7 clause:

8 “(iii) SPECIAL RULE FOR OXYGEN
9 GENERATING PORTABLE EQUIPMENT.—In
10 the case of oxygen generating portable
11 equipment referred to in the final rule pub-
12 lished in the Federal Register on Novem-
13 ber 9, 2006 (71 Fed. Reg. 65897–65899),
14 in applying clauses (i) and (ii)(I) each ref-
15 erence to ‘13 months’ is deemed a ref-
16 erence to ‘36 months’.”.

17 (b) EFFECTIVE DATE.—

18 (1) IN GENERAL.—Subject to paragraph (3),
19 the amendments made by subsection (a) shall apply
20 to oxygen equipment furnished on or after January
21 1, 2008.

22 (2) TRANSITION.—In the case of an individual
23 receiving oxygen equipment on December 31, 2007,
24 for which payment is made under section 1834(a) of
25 the Social Security Act (42 U.S.C. 1395m(a)), the

1 13-month period described in paragraph (5)(F)(i) of
2 such section, as amended by subsection (a), shall
3 begin on January 1, 2008, but in no case shall the
4 rental period for such equipment exceed 36 months.

5 (3) APPLICATION TO COMPETITIVE ACQUISITION.—The amendments made by subsection (a)
6 shall not apply to contracts entered into under sec-
7 tion 1847 of the Social Security Act (42 U.S.C.
8 1395w-3) pursuant to a bid submitted under such
9 section before July 21, 2007.

11 (c) STUDY AND REPORT.—

12 (1) STUDY.—The Secretary of Health and
13 Human Services shall conduct a study to examine
14 the service component and the equipment component
15 of the provision of oxygen to Medicare beneficiaries.
16 The study shall assess—

17 (A) the type of services provided and vari-
18 ation across suppliers in providing such serv-
19 ices;

20 (B) whether the services are medically nec-
21 essary or affect patient outcomes;

22 (C) whether the Medicare program pays
23 appropriately for equipment in connection with
24 the provision of oxygen;

1 (D) whether such program pays appro-
2 priately for necessary services;

3 (E) whether such payment in connection
4 with the provision of oxygen should be divided
5 between equipment and services, and if so, how;
6 and

7 (F) how such payment rate compares to a
8 competitively bid rate.

9 (2) REPORT.—Not later than 18 months after
10 the date of the enactment of this Act, the Secretary
11 of Health and Human Services shall submit to Con-
12 gress a report on the study conducted under para-
13 graph (1).

14 **SEC. 610. ADJUSTMENT FOR MEDICARE MENTAL HEALTH**
15 **SERVICES.**

16 (a) IN GENERAL.—For purposes of payment for serv-
17 ices furnished under the physician fee schedule under sec-
18 tion 1848 of the Social Security Act (42 U.S.C. 1395w-
19 4) during the applicable period, the Secretary of Health
20 and Human Services shall increase the amount otherwise
21 payable for applicable services by 5 percent.

22 (b) DEFINITIONS.—For purposes of subsection (a):

23 (1) APPLICABLE PERIOD.—The term “applica-
24 ble period” means the period beginning on January
25 1, 2008, and ending on December 31 of the year be-

1 fore the effective date of the first review after Janu-
2 ary 1, 2008, of work relative value units conducted
3 under section 1848(c)(2)(B)(i) of the Social Security
4 Act.

5 (2) APPLICABLE SERVICES.—The term “appli-
6 cable services” means procedure codes for services—

7 (A) in the categories of psychiatric thera-
8 peutic procedures furnished in office or other
9 outpatient facility settings, or inpatient hos-
10 pital, partial hospital or residential care facility
11 settings; and

12 (B) which cover insight oriented, behavior
13 modifying, or supportive psychotherapy and
14 interactive psychotherapy services in the
15 Healthcare Common Procedure Coding System
16 established by the Secretary of Health and
17 Human Services under section 1848(c)(5) of
18 such Act.

19 (c) IMPLEMENTATION.—Notwithstanding any other
20 provision of law, the Secretary of Health and Human
21 Services may implement this section by program instruc-
22 tion or otherwise.

1 **SEC. 611. EXTENSION OF BRACHYTHERAPY SPECIAL RULE.**

2 Section 1833(t)(16)(C) of the Social Security Act (42
3 U.S.C. 1395l(t)(16)(C)) is amended by striking “2008”
4 and inserting “2009”.

5 **SEC. 612. PAYMENT FOR PART B DRUGS.**

6 (a) APPLICATION OF CONSISTENT VOLUME
7 WEIGHTING IN COMPUTATION OF ASP.—In order to as-
8 sure that payments for drugs and biologicals under section
9 1847A of the Social Security Act (42 U.S.C. 1395w-3a)
10 are correct and consistent with law, the Secretary of
11 Health and Human Services shall, for payment for drugs
12 and biologicals furnished on or after July 1, 2008, com-
13 pute the volume-weighted average sales price using equa-
14 tion #2 (specified in appendix A of the report of the In-
15 spector General of the Department of Health and Human
16 Services on “Calculation of Volume-Weighted Average
17 Sales Price for Medicare Part B Prescription Drugs”
18 (February 2006; OEI-03-05-00310)) used by the Office
19 of Inspector General to calculate a volume-weighted ASP.

20 (b) IMPROVEMENTS IN THE COMPETITIVE ACQUISI-
21 TION PROGRAM (CAP).—

22 (1) CONTINUOUS OPEN ENROLLMENT; AUTO-
23 MATIC REENROLLMENT WITHOUT NEED FOR RE-
24 APPLICATION.—Subsection (a)(1)(A) of section
25 1847B of the Social Security Act (42 U.S.C. 1395w-
26 3b) is amended—

1 (A) in clause (ii), by striking “annually”
2 and inserting “on an ongoing basis”;

3 (B) in clause (iii), by striking “an annual
4 selection” and inserting “a selection (which
5 may be changed on an annual basis)” ; and

6 (C) by adding at the end the following:
7 “An election and selection described in clauses
8 (ii) and (iii) shall continue to be effective with-
9 out the need for any periodic reelection or re-
10 application or selection.”.

11 (2) PERMITTING VENDER TO DELIVER DRUGS
12 TO SITE OF ADMINISTRATION.—Subsection (b)(4)(E)
13 of such section is amended—

14 (A) by striking “or” at the end of clause
15 (I);

16 (B) by striking the period at the end of
17 clause (ii) and inserting “; or”; and

18 (C) by adding at the end the following new
19 clause:

20 “(iii) prevent a contractor from deliv-
21 ering drugs and biologicals to the site in
22 which the drugs or biologicals will be ad-
23 ministered.”.

1 (3) PHYSICIAN OUTREACH AND EDUCATION.—

2 Subsection (a)(1) of such section is amended by add-
3 ing at the end the following new subparagraph:

4 “(E) PHYSICIAN OUTREACH AND EDU-
5 CATION.—The Secretary shall conduct a pro-
6 gram of outreach to education physicians con-
7 cerning the program and the ongoing oppor-
8 tunity of physicians to elect to obtain drugs and
9 biologicals under the program.”.

10 (4) REBIDDING OF CONTRACTS.—The Secretary
11 of Health and Human Services shall provide for the
12 rebidding of contracts under section 1847B(e) of the
13 Social Security Act (42 U.S.C. 1395w-3b(c)) only
14 for periods on or after the expiration of the contract
15 in effect under such section as of the date of the en-
16 actment of this Act.

17 (e) TREATMENT OF CERTAIN DRUGS.—Section
18 1847A(b) of the Social Security Act (42 U.S.C. 1395w-
19 3a(b)) is amended—

20 (1) in paragraph (1), by inserting “paragraph
21 “(6) and” after “Subject to”; and

22 (2) by adding at the end the following new
23 paragraph:

24 “(6) SPECIAL RULE.—In applying subsection
25 (c)(6)(C)(ii), beginning with January 1, 2008, the

1 average sales price for drugs or biologicals described
2 in section 1842(o)(1)(G) is the lower of the average
3 sales price calculated including drugs or biologicals
4 to which such subsection applies and the average
5 sales price that would have been calculated if such
6 subsection were not applied.”.

7 (d) EFFECTIVE DATE.—Except as otherwise pro-
8 vided, the amendments made by this section shall apply
9 to drugs furnished on or after January 1, 2008.

10 **Subtitle B—Extension of Medicare** 11 **Rural Access Protections**

12 **SEC. 621. 2-YEAR EXTENSION OF FLOOR ON MEDICARE** 13 **WORK GEOGRAPHIC ADJUSTMENT.**

14 Section 1848(e)(1)(E) of such Act (42 U.S.C.
15 1395w–4(e)(1)(E)) is amended by striking “2008” and in-
16 serting “2010”.

17 **SEC. 622. 2-YEAR EXTENSION OF SPECIAL TREATMENT OF** 18 **CERTAIN PHYSICIAN PATHOLOGY SERVICES** 19 **UNDER MEDICARE.**

20 Section 542(c) of the Medicare, Medicaid, and
21 SCHIP Benefits Improvement and Protection Act of
22 2000, as amended by section 732 of the Medicare Pre-
23 scription Drug, Improvement, and Modernization Act of
24 2003, and section 104 of the Medicare Improvements and
25 Extension Act of 2006 (division B of Public Law 109–

1 432), is amended by striking “and 2007” and inserting
2 “2007, 2008, and 2009”.

3 **SEC. 623. 2-YEAR EXTENSION OF MEDICARE REASONABLE**
4 **COSTS PAYMENTS FOR CERTAIN CLINICAL**
5 **DIAGNOSTIC LABORATORY TESTS FUR-**
6 **NISHED TO HOSPITAL PATIENTS IN CERTAIN**
7 **RURAL AREAS.**

8 Section 416(b) of the Medicare Prescription Drug,
9 Improvement, and Modernization Act of 2003 (Public Law
10 108–173; 117 Stat. 2282; 42 U.S.C. 1395l–4(b)), as
11 amended by section 105 of the Medicare Improvement and
12 Extension Act of 2006 (division B of Public Law 109–
13 432), is amended by striking “3-year” and inserting “5-
14 year”.

15 **SEC. 624. 2-YEAR EXTENSION OF MEDICARE INCENTIVE**
16 **PAYMENT PROGRAM FOR PHYSICIAN SCAR-**
17 **CITY AREAS .**

18 (a) IN GENERAL.—Section 1833(u)(1) of the Social
19 Security Act (42 U.S.C. 1395l(u)(1)) is amended by strik-
20 ing “2008” and inserting “2010”.

21 (b) TRANSITION.—With respect to physicians’ serv-
22 ices furnished during 2008 and 2009, for purposes of sub-
23 section (a), the Secretary of Health and Human Services
24 shall use the primary care scarcity areas and the specialty
25 care scarcity areas (as identified in section 1833(u)(4))

1 that the Secretary was using under such subsection with
2 respect to physicians' services furnished on December 31,
3 2007.

4 **SEC. 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAY-**
5 **MENTS FOR GROUND AMBULANCE SERVICES**
6 **IN RURAL AREAS.**

7 Section 1834(l)(13) of the Social Security Act (42
8 U.S.C. 1395m(l)(13)) is amended—

9 (1) in subparagraph (A)—

10 (A) in the matter before clause (i), by
11 striking “furnished on or after July 1, 2004,
12 and before January 1, 2007,”;

13 (B) in clause (i), by inserting “for services
14 furnished on or after July 1, 2004, and before
15 January 1, 2007, and on or after January 1,
16 2008, and before January 1, 2010,” after “in
17 such paragraph,”; and

18 (C) in clause (ii), by inserting “for services
19 furnished on or after July 1, 2004, and before
20 January 1, 2007,” after “in clause (i),”; and

21 (2) in subparagraph (B)—

22 (A) in the heading, by striking “AFTER
23 2006” and inserting “FOR SUBSEQUENT PERI-
24 ODS”;

- 1 (B) by inserting “clauses (i) and (ii) of”
2 before “subparagraph (A)”; and
3 (C) by striking “in such subparagraph”
4 and inserting “in the respective clause”.

5 **SEC. 626. EXTENDING HOLD HARMLESS FOR SMALL RURAL**
6 **HOSPITALS UNDER THE HOPD PROSPECTIVE**
7 **PAYMENT SYSTEM.**

8 Section 1833(t)(7)(D)(i)(II) of the Social Security
9 Act (42 U.S.C. 1395l(t)(7)(D)(I)(II)) is amended—

- 10 (1) by striking “January 1, 2009” and insert-
11 ing “January 1, 2010”;
12 (2) by striking “2007, or 2008,”; and
13 (3) by striking “90 percent, and 85 percent, re-
14 spectively,” and inserting “, and with respect to
15 such services furnished after 2006 the applicable
16 percentage shall be 90 percent.”.

17 **Subtitle C—End Stage Renal**
18 **Disease Program**

19 **SEC. 631. CHRONIC KIDNEY DISEASE DEMONSTRATION**
20 **PROJECTS.**

21 (a) IN GENERAL.—The Secretary of Health and
22 Human Services (in this section referred to as the “Sec-
23 retary”), acting through the Director of the National In-
24 stitutes of Health, shall establish demonstration projects
25 to—

1 (1) increase public and medical community
2 awareness (particularly of those who treat patients
3 with diabetes and hypertension) about the factors
4 that lead to chronic kidney disease, how to prevent
5 it, how to diagnose it, and how to treat it;

6 (2) increase screening and use of prevention
7 techniques for chronic kidney disease for Medicare
8 beneficiaries and the general public (particularly
9 among patients with diabetes and hypertension,
10 where prevention techniques are well established and
11 early detection makes prevention possible); and

12 (3) enhance surveillance systems and expand re-
13 search to better assess the prevalence and incidence
14 of chronic kidney disease, (building on work done by
15 Centers for Disease Control and Prevention).

16 (b) SCOPE AND DURATION.—

17 (1) SCOPE.—The Secretary shall select at least
18 3 States in which to conduct demonstration projects
19 under this section. In selecting the States under this
20 paragraph, the Secretary shall take into account the
21 size of the population of individuals with end-stage
22 renal disease who are enrolled in part B of title
23 XVIII of the Social Security Act and ensure the par-
24 ticipation of individuals who reside in rural and
25 urban areas.

1 (2) DURATION.—The demonstration projects
2 under this section shall be conducted for a period
3 that is not longer than 5 years and shall begin on
4 January 1, 2009.

5 (c) EVALUATION AND REPORT.—

6 (1) EVALUATION.—The Secretary shall conduct
7 an evaluation of the demonstration projects con-
8 ducted under this section.

9 (2) REPORT.—Not later than 12 months after
10 the date on which the demonstration projects under
11 this section are completed, the Secretary shall sub-
12 mit to Congress a report on the evaluation con-
13 ducted under paragraph (1) together with rec-
14 ommendations for such legislation and administra-
15 tive action as the Secretary determines appropriate.

16 **SEC. 632. MEDICARE COVERAGE OF KIDNEY DISEASE PA-**
17 **TIENT EDUCATION SERVICES.**

18 (a) COVERAGE OF KIDNEY DISEASE EDUCATION
19 SERVICES.—

20 (1) COVERAGE.—Section 1861(s)(2) of the So-
21 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
22 ed—

23 (A) in subparagraph (Z), by striking
24 “and” after the semicolon at the end;

1 (B) in subparagraph (AA), by adding
2 “and” after the semicolon at the end; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(BB) kidney disease education services
6 (as defined in subsection (ccc));”.

7 (2) SERVICES DESCRIBED.—Section 1861 of
8 the Social Security Act (42 U.S.C. 1395x) is amend-
9 ed by adding at the end the following new sub-
10 section:

11 “Kidney Disease Education Services
12 “(ccc)(1) The term ‘kidney disease education serv-
13 ices’ means educational services that are—

14 “(A) furnished to an individual with stage IV
15 chronic kidney disease who, according to accepted
16 clinical guidelines identified by the Secretary, will re-
17 quire dialysis or a kidney transplant;

18 “(B) furnished, upon the referral of the physi-
19 cian managing the individual’s kidney condition, by
20 a qualified person (as defined in paragraph (2)); and

21 “(C) designed—

22 “(i) to provide comprehensive information
23 (consistent with the standards developed under
24 paragraph (3)) regarding—

1 “(I) the management of comorbidities,
2 including for purposes of delaying the need
3 for dialysis;

4 “(II) the prevention of uremic com-
5 plications; and

6 “(III) each option for renal replace-
7 ment therapy (including hemodialysis and
8 peritoneal dialysis at home and in-center
9 as well as vascular access options and
10 transplantation);

11 “(ii) to ensure that the individual has the
12 opportunity to actively participate in the choice
13 of therapy; and

14 “(iii) to be tailored to meet the needs of
15 the individual involved.

16 “(2) The term ‘qualified person’ means a physician,
17 physician assistant, nurse practitioner, or clinical nurse
18 specialist who furnishes services for which payment may
19 be made under the fee schedule established under section
20 1848. Such term does not include a renal dialysis facility.

21 “(3) The Secretary shall set standards for the con-
22 tent of such information to be provided under paragraph
23 (1)(C)(i) after consulting with physicians, other health
24 professionals, health educators, professional organizations,
25 accrediting organizations, kidney patient organizations, di-

1 dialysis facilities, transplant centers, network organizations
2 described in section 1881(c)(2), and other knowledgeable
3 persons. To the extent possible the Secretary shall consult
4 with a person or entity described in the previous sentence,
5 other than a dialysis facility, that has not received indus-
6 try funding from a drug or biological manufacturer or di-
7 alysis facility.

8 “(4) In promulgating regulations to carry out this
9 subsection, the Secretary shall ensure that each individual
10 who is eligible for benefits for kidney disease education
11 services under this title receives such services in a timely
12 manner to maximize the benefit of those services.

13 “(5) The Secretary shall monitor the implementation
14 of this subsection to ensure that individuals who are eligi-
15 ble for benefits for kidney disease education services re-
16 ceive such services in the manner described in paragraph
17 (4).

18 “(6) No individual shall be eligible to be provided
19 more than 6 sessions of kidney disease education services
20 under this title.”.

21 (3) PAYMENT UNDER THE PHYSICIAN FEE
22 SCHEDULE.—Section 1848(j)(3) of the Social Secu-
23 rity Act (42 U.S.C. 1395w-4(j)(3)) is amended by
24 inserting “(2)(BB),” after “(2)(AA),”.

1 (4) LIMITATION ON NUMBER OF SESSIONS.—

2 Section 1862(a)(1) of the Social Security Act (42
3 U.S.C. 1395y(a)(1)) is amended—

4 (A) in subparagraph (M), by striking
5 “and” at the end;

6 (B) in subparagraph (N), by striking the
7 semicolon at the end and inserting “, and”; and

8 (C) by adding at the end the following new
9 subparagraph:

10 “(O) in the case of kidney disease edu-
11 cation services (as defined in section
12 1861(ccc)), which are furnished in excess of the
13 number of sessions covered under such sec-
14 tion;”.

15 (5) GAO REPORT.—Not later than September
16 1, 2010, the Comptroller General of the United
17 States shall submit to Congress a report on the fol-
18 lowing:

19 (A) The number of Medicare beneficiaries
20 who are eligible to receive benefits for kidney
21 disease education services (as defined in section
22 1861(ccc) of the Social Security Act, as added
23 by paragraph (2)) under title XVIII of such Act
24 and who receive such services.

1 (B) The extent to which there is a suffi-
2 cient amount of physicians, physician assist-
3 ants, nurse practitioners, and clinical nurse spe-
4 cialists to furnish kidney disease education serv-
5 ices (as so defined) under such title and wheth-
6 er or not renal dialysis facilities (and appro-
7 priate employees of such facilities) should be in-
8 cluded as an entity eligible under such section
9 to furnish such services.

10 (C) Recommendations, if appropriate, for
11 renal dialysis facilities (and appropriate employ-
12 ees of such facilities) to structure kidney dis-
13 ease education services (as so defined) in a
14 manner that is objective and unbiased and that
15 provides a range of options and alternative loca-
16 tions for renal replacement therapy and man-
17 agement of co-morbidities that may delay the
18 need for dialysis.

19 (b) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to services furnished on or after
21 January 1, 2009.

1 **SEC. 633. REQUIRED TRAINING FOR PATIENT CARE DIALY-**
2 **SIS TECHNICIANS.**

3 Section 1881 of the Social Security Act (42 U.S.C.
4 1395rr) is amended by adding the following new sub-
5 section:

6 “(h)(1) Except as provided in paragraph (2), a pro-
7 vider of services or a renal dialysis facility may not use,
8 for more than 12 months during 2009, or for any period
9 beginning on January 1, 2010, any individual as a patient
10 care dialysis technician unless the individual—

11 “(A) has completed a training program in the
12 care and treatment of an individual with chronic
13 kidney failure who is undergoing dialysis treatment;
14 and

15 “(B) has been certified by a nationally recog-
16 nized certification entity for dialysis technicians.

17 “(2)(A) A provider of services or a renal dialysis facil-
18 ity may permit an individual enrolled in a training pro-
19 gram described in paragraph (1)(A) to serve as a patient
20 care dialysis technician while they are so enrolled.

21 “(B) The requirements described in subparagraphs
22 (A), (B), and (C) of paragraph (1) do not apply to an
23 individual who has performed dialysis-related services for
24 at least 5 years.

25 “(3) For purposes of paragraph (1), if, since the most
26 recent completion by an individual of a training program

1 described in paragraph (1)(A), there has been a period
2 of 24 consecutive months during which the individual has
3 not furnished dialysis-related services for monetary com-
4 pensation, such individual shall be required to complete
5 a new training program or become recertified as described
6 in paragraph (1)(B).

7 “(4) A provider of services or a renal dialysis facility
8 shall provide such regular performance review and regular
9 in-service education as assures that individuals serving as
10 patient care dialysis technicians for the provider or facility
11 are competent to perform dialysis-related services.”.

12 **SEC. 634. MEDPAC REPORT ON TREATMENT MODALITIES**
13 **FOR PATIENTS WITH KIDNEY FAILURE.**

14 (a) EVALUATION.—

15 (1) IN GENERAL.—Not later than March 1,
16 2009, the Medicare Payment Advisory Commission
17 (established under section 1805 of the Social Secu-
18 rity Act) shall submit to the Secretary and Congress
19 a report evaluating the barriers that exist to increas-
20 ing the number of individuals with end-stage renal
21 disease who elect to receive home dialysis services
22 under the Medicare program under title XVIII of
23 the Social Security Act (42 U.S.C. 1395 et seq.).

24 (2) REPORT DETAILS.—The report shall include
25 the following:

1 (A) A review of Medicare home dialysis
2 demonstration projects initiated before the date
3 of the enactment of this Act, and the results of
4 such demonstration projects and recommenda-
5 tions for future Medicare home dialysis dem-
6 onstration projects or Medicare program
7 changes that will test models that can improve
8 Medicare beneficiary access to home dialysis.

9 (B) A comparison of current Medicare
10 home dialysis costs and payments with current
11 in-center and hospital dialysis costs and pay-
12 ments.

13 (C) An analysis of the adequacy of Medi-
14 care reimbursement for patient training for
15 home dialysis (including hemodialysis and peri-
16 toneal dialysis) and recommendations for ensur-
17 ing appropriate payment for such home dialysis
18 training.

19 (D) A catalogue and evaluation of the in-
20 centives and disincentives in the current reim-
21 bursement system that influence whether pa-
22 tients receive home dialysis services or other
23 treatment modalities.

1 (E) An evaluation of patient education
2 services and how such services impact the treat-
3 ment choices made by patients.

4 (F) Recommendations for implementing in-
5 centives to encourage patients to elect to receive
6 home dialysis services or other treatment mo-
7 dalities under the Medicare program

8 (3) SCOPE OF REVIEW.—In preparing the re-
9 port under paragraph (1), the Medicare Payment
10 Advisory Commission shall consider a variety of per-
11 spectives, including the perspectives of physicians,
12 other health care professionals, hospitals, dialysis fa-
13 cilities, health plans, purchasers, and patients.

14 **SEC. 635. ADJUSTMENT FOR ERYTHROPOIETIN STIMU-**
15 **LATING AGENTS (ESAS).**

16 (a) IN GENERAL.—Subsection (b)(13) of section
17 1881 of the Social Security Act (42 U.S.C. 1395rr) is
18 amended—

19 (1) in subparagraph (A)(iii), by striking “For
20 such drugs” and inserting “Subject to subparagraph
21 (C), for such drugs”; and

22 (2) by adding at the end the following new sub-
23 paragraph:

24 “(C)(i) The payment amounts under this title for
25 erythropoietin furnished during 2008 or 2009 to an indi-

1 vidual with end stage renal disease by a large dialysis fa-
2 cility (as defined in subparagraph (D)) (whether to indi-
3 viduals in the facility or at home), in an amount equal
4 to \$8.75 per thousand units (rounded to the nearest 100
5 units) or, if less, 102 percent of the average sales price
6 (as determined under section 1847A) for such drug or bio-
7 logical.

8 “(ii) The payment amounts under this title for
9 darbepoetin alfa furnished during 2008 or 2009 to an in-
10 dividual with end stage renal disease by a large dialysis
11 facility (as defined in clause (iii)) (whether to individuals
12 in the facility or at home), in an amount equal to \$2.92
13 per microgram or, if less, 102 percent of the average sales
14 price (as determined under section 1847A) for such drug
15 or biological.

16 “(iii) For purposes of this subparagraph, the term
17 ‘large dialysis facility’ means a provider of services or
18 renal dialysis facility that is owned or managed by a cor-
19 porate entity that, as of July 24, 2007, owns or manages
20 300 or more such providers or facilities, and includes a
21 successor to such a corporate entity”.

22 (b) NO IMPACT ON DRUG ADD-ON PAYMENT.—Noth-
23 ing in the amendments made by subsection (a) shall be
24 construed to affect the amount of any payment adjust-

1 ment made under section 1881(b)(12)(B)(ii) of the Social
2 Security Act (42 U.S.C. 1395rr(b)(12)(B)(ii)).

3 **SEC. 636. SITE NEUTRAL COMPOSITE RATE.**

4 Subsection (b)(12)(A) of section 1881 of the Social
5 Security Act (42 U.S.C. 1395rr) is amended by adding
6 at the end the following new sentence: “Under such sys-
7 tem the payment rate for dialysis services furnished on
8 or after January 1, 2008, by providers of such services
9 for hospital-based facilities shall be the same as the pay-
10 ment rate (computed without regard to this sentence) for
11 such services furnished by renal dialysis facilities that are
12 not hospital-based, except that in applying the geographic
13 index under subparagraph (D) to hospital-based facilities,
14 the labor share shall be based on the labor share otherwise
15 applied for such facilities.”.

16 **SEC. 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM AND**
17 **QUALITY INCENTIVE PAYMENTS.**

18 (a) DEVELOPMENT OF ESRD BUNDLING SYSTEM.—
19 Subsection (b) of section 1881 of the Social Security Act
20 (42 U.S.C. 1395rr) is further amended—

21 (1) in paragraph (12)(A), by striking “In lieu
22 of payment” and inserting “Subject to paragraph
23 (14), in lieu of payment”;

24 (2) in the second sentence of paragraph
25 (12)(F)—

1 (A) by inserting “or paragraph (14)” after
2 “this paragraph”; and

3 (B) by inserting “or under the system
4 under paragraph (14)” after “subparagraph
5 (B)”;
6 (3) in paragraph (12)(H)—

7 (A) by inserting “or paragraph (14)” after
8 “under this paragraph” the first place it ap-
9 pears; and

10 (B) by inserting before the period at the
11 end the following: “or, under paragraph (14),
12 the identification of renal dialysis services in-
13 cluded in the bundled payment, the adjustment
14 for outliers, the identification of facilities to
15 which the phase-in may apply, and the deter-
16 mination of payment amounts under subpara-
17 graph (A) under such paragraph, and the appli-
18 cation of paragraph (13)(C)(iii)”;

19 (4) in paragraph (13)—

20 (A) in subparagraph (A), by striking “The
21 payment amounts” and inserting “subject to
22 paragraph (14), the payment amounts”; and

23 (B) in subparagraph (B)—

24 (i) in clause (i), by striking “(i)” after
25 “(B)” and by inserting “, subject to para-

1 graph (14)” before the period at the end;
2 and

3 (ii) by striking clause (ii); and

4 (5) by adding at the end the following new
5 paragraph:

6 “(14)(A) Subject to subparagraph (E), for services
7 furnished on or after January 1, 2010, the Secretary shall
8 implement a payment system under which a single pay-
9 ment is made under this title for renal dialysis services
10 (as defined in subparagraph (B)) in lieu of any other pay-
11 ment (including a payment adjustment under paragraph
12 (12)(B)(ii)) for such services and items furnished pursu-
13 ant to paragraph (4). In implementing the system the Sec-
14 retary shall ensure that the estimated total amount of pay-
15 ments under this title for 2010 for renal dialysis services
16 shall equal 96 percent of the estimated amount of pay-
17 ments for such services, including payments under para-
18 graph (12)(B)(ii), that would have been made if such sys-
19 tem had not been implemented.

20 “(B) For purposes of this paragraph, the term ‘renal
21 dialysis services’ includes—

22 “(i) items and services included in the
23 composite rate for renal dialysis services as of
24 December 31, 2009;

1 “(ii) erythropoietin stimulating agents fur-
2 nished to individuals with end stage renal dis-
3 ease;

4 “(iii) other drugs and biologicals and diag-
5 nostic laboratory tests, that the Secretary iden-
6 tifies as commonly used in the treatment of
7 such patients and for which payment was (be-
8 fore the application of this paragraph) made
9 separately under this title, and any oral equiva-
10 lent form of such drugs and biologicals or of
11 drugs and biologicals described in clause (ii);
12 and

13 “(iv) home dialysis training for which pay-
14 ment was (before the application of this para-
15 graph) made separately under this section.

16 Such term does not include vaccines.

17 “(C) The system under this paragraph may provide
18 for payment on the basis of services furnished during a
19 week or month or such other appropriate unit of payment
20 as the Secretary specifies.

21 “(D) Such system—

22 “(i) shall include a payment adjustment based
23 on case mix that may take into account patient
24 weight, body mass index, comorbidities, length of

1 time on dialysis, age, race, ethnicity, and other ap-
2 propriate factors;

3 “(ii) shall include a payment adjustment for
4 high cost outliers due to unusual variations in the
5 type or amount of medically necessary care, includ-
6 ing variations in the amount of erythropoietin stimu-
7 lating agents necessary for anemia management; and

8 “(iii) may include such other payment adjust-
9 ments as the Secretary determines appropriate, such
10 as a payment adjustment—

11 “(I) by a geographic index, such as the
12 index referred to in paragraph (12)(D), as the
13 Secretary determines to be appropriate;

14 “(II) for pediatric providers of services and
15 renal dialysis facilities;

16 “(III) for low volume providers of services
17 and renal dialysis facilities;

18 “(IV) for providers of services or renal di-
19 alysis facilities located in rural areas; and

20 “(V) for providers of services or renal di-
21 alysis facilities that are not large dialysis facili-
22 ties.

23 “(E) The Secretary may provide for a phase-in of the
24 payment system described in subparagraph (A) for serv-
25 ices furnished by a provider of services or renal dialysis

1 facility described in any of subclauses (II) through (V) of
2 subparagraph (D)(iii), but such payment system shall be
3 fully implemented for services furnished in the case of any
4 such provider or facility on or after January 1, 2013.

5 “(F) The Secretary shall apply the annual increase
6 that would otherwise apply under subparagraph (F) of
7 paragraph (12) to payment amounts established under
8 such paragraph (if this paragraph did not apply) in an
9 appropriate manner under this paragraph.”.

10 (6) PROHIBITION OF UNBUNDLING.—Section
11 1862(a) of such Act (42 U.S.C. 1395y(a)) is amend-
12 ed—

13 (A) by striking “or” at the end of para-
14 graph (21);

15 (B) by striking the period at the end of
16 paragraph (22) and inserting “; or”; and

17 (C) by inserting after paragraph (22) the
18 following new paragraph:

19 “(23) where such expenses are for renal dialysis
20 services (as defined in subparagraph (B) of section
21 1881(b)(14)) for which payment is made under such
22 section (other than under subparagraph (E) of such
23 section) unless such payment is made under such
24 section to a provider of services or a renal dialysis
25 facility for such services.”.

1 (b) QUALITY INCENTIVE PAYMENTS.—Section 1881
2 of such Act is amended by adding at the end the following
3 new subsection:

4 “(i) QUALITY INCENTIVE PAYMENTS IN THE END-
5 STAGE RENAL DISEASE PROGRAM.—

6 “(1) QUALITY INCENTIVE PAYMENTS FOR
7 SERVICES FURNISHED IN 2008, 2009, AND 2010.—

8 “(A) IN GENERAL.—With respect to renal
9 dialysis services furnished during a performance
10 period (as defined in subparagraph (B)) by a
11 provider of services or renal dialysis facility that
12 the Secretary determines meets the applicable
13 performance standard for the period under sub-
14 paragraph (C) and reports on measures for
15 2009 and 2010 under subparagraph (D) for
16 such services, in addition to the amount other-
17 wise paid under this section, subject to sub-
18 paragraph (G), there also shall be paid to the
19 provider or facility an amount equal to the ap-
20 plicable percentage (specified in subparagraph
21 (E) for the period) of the Secretary’s estimate
22 (based on claims submitted not later than two
23 months after the end of the performance pe-
24 riod) of the amount specified in subparagraph
25 (F) for such period.

“(B) PERFORMANCE PERIOD.—In this paragraph, the term ‘performance period’ means each of the following:

“(i) The period beginning on July 1, 2008, and ending on December 31, 2008.

“(ii) 2009.

“(iii) 2010.

“(C) PERFORMANCE STANDARD.—

“(i) 2008.—For the performance period occurring in 2008, the applicable performance standards for a provider or facility under this subparagraph are—

“(I) 92 percent or more of individuals with end stage renal disease receiving erythropoetin stimulating agents who have an average hematocrit of 33.0 percent or more; and

“(II) less than a percentage, specified by the Secretary, of individuals with end stage renal disease receiving erythropoetin stimulating agents who have an average hematocrit of 39.0 percent or more.

“(ii) 2009 AND 2010.—For the 2009 and 2010 performance periods, the appli-

1 cable performance standard for a provider
2 or facility under this subparagraph is suc-
3 cessful performance (relative to national
4 average) on—

5 “(I) such measures of anemia
6 management as the Secretary shall
7 specify, including measures of hemo-
8 globin levels or hematocrit levels for
9 erythropoietin stimulating agents that
10 are consistent with the labeling for
11 dosage of erythropoietin stimulating
12 agents approved by the Food and
13 Drug Administration for treatment of
14 anemia in patients with end stage
15 renal disease, taking into account
16 variations in hemoglobin ranges or
17 hematocrit levels of patients; and

18 “(II) such other measures, relat-
19 ing to subjects described in subpara-
20 graph (D)(i), as the Secretary may
21 specify.

22 “(D) REPORTING PERFORMANCE MEAS-
23 URES.—The performance measures under this
24 subparagraph to be reported shall include—

“(i) such measures as the Secretary specifies, before the beginning of the performance period involved and taking into account measures endorsed by the National Quality Forum, including, to the extent feasible measures on—

“(I) iron management;

“(II) dialysis adequacy; and

“(III) vascular access, including for maximizing the placement of arterial venous fistula; and

“(ii) to the extent feasible, such measure (or measures) of patient satisfaction as the Secretary shall specify.

The provider or facility submitting information on such measures shall attest to the completeness and accuracy of such information.

“(E) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for—

“(i) the performance period occurring in 2008, is 1.0 percent;

“(ii) the 2009 performance period, is 2.0 percent; and

1 “(iii) the 2010 performance period, is
2 2.0 percent.

3 In the case of any performance period which is
4 less than an entire year, the applicable percent-
5 age specified in this subparagraph shall be mul-
6 tiplied by the ratio of the number of months in
7 the year to the number of months in such per-
8 formance period. In the case of 2010, the appli-
9 cable percentage specified in this subparagraph
10 shall be multiplied by the Secretary’s estimate
11 of the ratio of the aggregate payment amount
12 described in subparagraph (F)(i) that would
13 apply in 2010 if paragraph (14) did not apply,
14 to the aggregate payment base under subpara-
15 graph (F)(ii) for 2010.

16 “(F) PAYMENT BASE.—The payment base
17 described in this subparagraph for a provider or
18 facility is—

19 “(i) for performance periods before
20 2010, the payment amount determined
21 under paragraph (12) for services fur-
22 nished by the provider or facility during
23 the performance period, including the drug
24 payment adjustment described in subpara-
25 graph (B)(ii) of such paragraph; and

1 “(ii) for the 2010 performance period
2 is the amount determined under paragraph
3 (14) for services furnished by the provider
4 or facility during the period.

5 “(G) LIMITATION ON FUNDING.—

6 “(i) IN GENERAL.—If the Secretary
7 determines that the total payments under
8 this paragraph for a performance period is
9 projected to exceed the dollar amount spec-
10 ified in clause (ii) for such period, the Sec-
11 retary shall reduce, in a pro rata manner,
12 the amount of such payments for each pro-
13 vider or facility for such period to elimi-
14 nate any such projected excess for the pe-
15 riod.

16 “(ii) DOLLAR AMOUNT.—The dollar
17 amount specified in this clause—

18 “(I) for the performance period
19 occurring in 2008, is \$50,000,000;

20 “(II) for the 2009 performance
21 period is \$100,000,000; and

22 “(III) for the 2010 performance
23 period is \$150,000,000.

1 “(H) FORM OF PAYMENT.—The payment
2 under this paragraph shall be in the form of a
3 single consolidated payment.

4 “(2) QUALITY INCENTIVE PAYMENTS FOR FA-
5 CILITIES AND PROVIDERS FOR 2011.—

6 “(A) INCREASED PAYMENT.—For 2011, in
7 the case of a provider or facility that, for the
8 performance period (as defined in subparagraph
9 (B))—

10 “(i) meets (or exceeds) the perform-
11 ance standard for anemia management
12 specified in paragraph (1)(C)(ii)(I);

13 “(ii) has substantially improved per-
14 formance or exceeds a performance stand-
15 ard (as determined under subparagraph
16 (E)); and

17 “(iii) reports measures specified in
18 paragraph (1)(D),

19 with respect to renal dialysis services furnished
20 by the provider or facility during the quality
21 bonus payment period (as specified in subpara-
22 graph (C)) the payment amount otherwise made
23 to such provider or facility under subsection
24 (b)(14) shall be increased, subject to subpara-
25 graph (F), by the applicable percentage speci-

1 fied in subparagraph (D). Payment amounts
2 under paragraph (1) shall not be counted for
3 purposes of applying the previous sentence.

4 “(B) PERFORMANCE PERIOD.—In this
5 paragraph, the term ‘performance period’
6 means a multi-month period specified by the
7 Secretary .

8 “(C) QUALITY BONUS PAYMENT PERIOD.—
9 In this paragraph, the term ‘quality bonus pay-
10 ment period’ means, with respect to a perform-
11 ance period, a multi-month period beginning on
12 January 1, 2011, specified by the Secretary
13 that begins at least 3 months (but not more
14 than 9 months) after the end of the perform-
15 ance period.

16 “(D) APPLICABLE PERCENTAGE.—The ap-
17 plicable percentage specified in this subpara-
18 graph is a percentage, not to exceed the 2.0
19 percent, specified by the Secretary consistent
20 with subparagraph (F). Such percentage may
21 vary based on the level of performance and im-
22 provement. The applicable percentage specified
23 in this subparagraph shall be multiplied by the
24 ratio applied under the third sentence of para-
25 graph (1)(E) for 2010.

1 “(E) PERFORMANCE STANDARD.—Based
2 on performance of a provider of services or a
3 renal dialysis facility on performance measures
4 described in paragraph (1)(D) for a perform-
5 ance period, the Secretary shall determine a
6 composite score for such period.

7 “(F) LIMITATION ON FUNDING.—If the
8 Secretary determines that the total amount to
9 be paid under this paragraph for a quality
10 bonus payment period is projected to exceed
11 \$200,000,000, the Secretary shall reduce, in a
12 uniform manner, the applicable percentage oth-
13 erwise applied under subparagraph (D) for
14 services furnished during the period to elimi-
15 nate any such projected excess.

16 “(3) APPLICATION.—

17 “(A) IMPLEMENTATION.—Notwithstanding
18 any other provision of law, the Secretary may
19 implement by program instruction or otherwise
20 this subsection.

21 “(B) LIMITATIONS ON REVIEW.—

22 “(i) IN GENERAL.—There shall be no
23 administrative or judicial review under sec-
24 tion 1869 or 1878 or otherwise of—

1 “(I) the determination of per-
2 formance measures and standards
3 under this subsection;

4 “(II) the determination of suc-
5 cessful reporting, including a deter-
6 mination of composite scores; and

7 “(III) the determination of the
8 quality incentive payments made
9 under this subsection.

10 “(ii) TREATMENT OF DETERMINA-
11 TIONS.—A determination under this sub-
12 paragraph shall not be treated as a deter-
13 mination for purposes of section 1869.

14 “(4) TECHNICAL ASSISTANCE.—The Secretary
15 shall identify or establish an appropriately skilled
16 group or organization, such as the ESRD Networks,
17 to provide technical assistance to consistently low-
18 performing facilities or providers that are in the bot-
19 tom quintile.

20 “(5) PUBLIC REPORTING.—

21 “(A) ANNUAL NOTICE.—The Secretary
22 shall provide an annual written notification to
23 each individual who is receiving renal dialysis
24 services from a provider of services or renal di-
25 alysis facility that—

1 “(i) informs such individual of the
2 composite scores described in subpara-
3 graph (A) and other relevant quality meas-
4 ures with respect to providers of services
5 or renal dialysis facilities in the local area;

6 “(ii) compares such scores and meas-
7 ures to the average local and national
8 scores and measures; and

9 “(iii) provides information on how to
10 access additional information on quality of
11 such services furnished and options for al-
12 ternative providers and facilities.

13 “(B) CERTIFICATES.—The Secretary shall
14 provide certificates to facilities and providers
15 who provide services to individuals with end-
16 stage renal disease under this title to display in
17 patient areas. The certificate shall indicate the
18 composite score obtained by the facility or pro-
19 vider under the quality initiative.

20 “(C) WEB-BASED QUALITY LIST.—The
21 Secretary shall establish a web-based list of fa-
22 cilities and providers who furnish renal dialysis
23 services under this section that indicates their
24 composite score of each provider and facility.

1 “(6) RECOMMENDATIONS FOR REPORTING AND
2 QUALITY INCENTIVE INITIATIVE FOR PHYSI-
3 CIANS.—The Secretary shall develop recommenda-
4 tions for applying quality incentive payments under
5 this subsection to physicians who receive the month-
6 ly capitated payment under this title. Such rec-
7 ommendations shall include the following:

8 “(A) Recommendations to include pediatric
9 specific measures for physicians with at least
10 50 percent of their patients with end stage
11 renal disease being individuals under 18 years
12 of age.

13 “(B) Recommendations on how to struc-
14 ture quality incentive payments for physicians
15 who demonstrate improvements in quality or
16 who attain quality standards, as specified by
17 the Secretary.

18 “(7) REPORTS.—

19 “(A) INITIAL REPORT.—Not later than
20 January 1, 2013, the Secretary shall submit to
21 Congress a report on the implementation of the
22 bundled payment system under subsection
23 (b)(14) and the quality initiative under this
24 subsection. Such report shall include the fol-
25 lowing information:

1 “(i) A comparison of the aggregate
2 payments under subsection (b)(14) for
3 items and services to the cost of such items
4 and services.

5 “(ii) The changes in utilization rates
6 for erythropoietin stimulating agents.

7 “(iii) The mode of administering such
8 agents, including information on the pro-
9 portion of such individuals receiving such
10 agents intravenously as compared to
11 subcutaneously.

12 “(iv) The frequency of dialysis.

13 “(v) Other differences in practice pat-
14 terns, such as the adoption of new tech-
15 nology, different modes of practice, and
16 variations in use of drugs other than drugs
17 described in clause (iii).

18 “(vi) The performance of facilities and
19 providers under paragraph (2).

20 “(vii) Other recommendations for leg-
21 islative and administrative actions deter-
22 mined appropriate by the Secretary.

23 “(B) SUBSEQUENT REPORT.—Not later
24 than January 1, 2015, the Secretary shall sub-
25 mit to Congress a report that contains the in-

1 formation described in each of clauses (ii)
2 through (vii) of subparagraph (A) and a com-
3 parison of the results of the payment system
4 under subsection (b)(14) for renal dialysis serv-
5 ices furnished during the 2-year period begin-
6 ning on January 1, 2013, and the results of
7 such payment system for such services fur-
8 nished during the previous two-year period.”.

9 **SEC. 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM.**

10 Not later than March 1, 2012, the Medicare Payment
11 Advisory Commission (established under section 1805 of
12 the Social Security Act) shall submit to Congress a report
13 on the implementation of the payment system under sec-
14 tion 1881(b)(14) of the Social Security Act (as added by
15 section 7) for renal dialysis services and related services
16 (defined in subparagraph (B) of such section). Such report
17 shall include, with respect to such payment system for
18 such services, an analysis of each of the following:

19 (1) An analysis of the overall adequacy of pay-
20 ment under such system for all such services.

21 (2) An analysis that compares the adequacy of
22 payment under such system for services furnished
23 by—

1 (A) a provider of services or renal dialysis
2 facility that is described in section
3 1881(b)(13)(C)(iv) of the Social Security Act;

4 (B) a provider of services or renal dialysis
5 facility not described in such section;

6 (C) a hospital-based facility;

7 (D) a freestanding renal dialysis facility;

8 (E) a renal dialysis facility located in an
9 urban area; and

10 (F) a renal dialysis facility located in a
11 rural area.

12 (3) An analysis of the financial status of pro-
13 viders of such services and renal dialysis facilities,
14 including access to capital, return on equity, and re-
15 turn on capital.

16 (4) An analysis of the adequacy of payment
17 under such method and the adequacy of the quality
18 improvement payments under section 1881(i) of the
19 Social Security Act in ensuring that payments for
20 such services under the Medicare program are con-
21 sistent with costs for such services.

22 (5) Recommendations, if appropriate, for modi-
23 fications to such payment system.

1 **SEC. 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN.**

2 (a) STUDY.—The Inspector General of the Depart-
3 ment of Health and Human Services shall conduct a study
4 on the following:

5 (1) The dosing guidelines, standards, protocols,
6 and algorithms for erythropoietin stimulating
7 agents recommended or used by providers of services
8 and renal dialysis facilities that are described in sec-
9 tion 1881(b)(13)(C)(iv) of the Social Security Act
10 and providers and facilities that are not described in
11 such section.

12 (2) The extent to which such guidelines, stand-
13 ards, protocols, and algorithms are consistent with
14 the labeling of the Food and Drug Administration
15 for such agents.

16 (3) The extent to which physicians sign stand-
17 ing orders for such agents that are consistent with
18 such guidelines, standards, protocols, and algorithms
19 recommended or used by the provider or facility in-
20 volved.

21 (4) The extent to which the prescribing deci-
22 sions of physicians, with respect to such agents, are
23 independent of—

24 (A) such relevant guidelines, standards,
25 protocols, and algorithms; or

1 (B) recommendations of an anemia man-
2 agement nurse or other appropriate employee of
3 the provider or facility involved.

4 (5) The role of medical directors of providers of
5 services and renal dialysis facilities and the financial
6 relationships between such providers and facilities
7 and the physicians hired as medical directors of such
8 providers and facilities, respectively.

9 (b) REPORT.—Not later than January 1, 2009, the
10 Inspector General of the Department of Health and
11 Human Services shall submit to Congress a report on the
12 study conducted under subsection (a), together with such
13 recommendations as the Inspector General determines ap-
14 propriate.

15 **Subtitle D—Miscellaneous**

16 **SEC. 651. LIMITATION ON EXCEPTION TO THE PROHIBI-** 17 **TION ON CERTAIN PHYSICIAN REFERRALS** 18 **FOR HOSPITALS.**

19 (a) IN GENERAL.—Section 1877 of the Social Secu-
20 rity Act (42 U.S.C. 1395) is amended—

21 (1) in subsection (d)(2)—

22 (A) in subparagraph (A), by striking
23 “and” at the end;

24 (B) in subparagraph (B), by striking the
25 period at the end and inserting “; and”; and

1 (C) by adding at the end the following new
2 subparagraph:

3 “(C) if the entity is a hospital, the hospital
4 meets the requirements of paragraph (3)(D).”;
5 (2) in subsection (d)(3)—

6 (A) in subparagraph (B), by striking
7 “and” at the end;

8 (B) in subparagraph (C), by striking the
9 period at the end and inserting “; and”; and

10 (C) by adding at the end the following new
11 subparagraph:

12 “(D) the hospital meets the requirements
13 described in subsection (i)(1) not later than 18
14 months after the date of the enactment of this
15 subparagraph.”; and

16 (3) by adding at the end the following new sub-
17 section:

18 “(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY
19 FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVEST-
20 MENT PROHIBITION.—

21 “(1) REQUIREMENTS DESCRIBED.—For pur-
22 poses of paragraphs subsection (d)(3)(D), the re-
23 quirements described in this paragraph for a hos-
24 pital are as follows:

1 “(A) PROVIDER AGREEMENT.—The hos-
2 pital had a provider agreement under section
3 1866 in effect on July 24, 2007.

4 “(B) PROHIBITION OF EXPANSION OF FA-
5 CILITY CAPACITY.—The number of operating
6 rooms and beds of the hospital at any time on
7 or after the date of the enactment of this sub-
8 section are no greater than the number of oper-
9 ating rooms and beds as of such date.

10 “(C) PREVENTING CONFLICTS OF INTER-
11 EST.—

12 “(i) The hospital submits to the Sec-
13 retary an annual report containing a de-
14 tailed description of—

15 “(I) the identity of each physi-
16 cian owner and any other owners of
17 the hospital; and

18 “(II) the nature and extent of all
19 ownership interests in the hospital.

20 “(ii) The hospital has procedures in
21 place to require that any referring physi-
22 cian owner discloses to the patient being
23 referred, by a time that permits the pa-
24 tient to make a meaningful decision re-

1 garding the receipt of care ,as determined
2 by the Secretary—

3 “(I) the ownership interest of
4 such referring physician in the hos-
5 pital; and

6 “(II) if applicable, any such own-
7 ership interest of the treating physi-
8 cian.

9 “(iii) The hospital does not condition
10 any physician ownership interests either di-
11 rectly or indirectly on the physician owner
12 making or influencing referrals to the hos-
13 pital or otherwise generating business for
14 the hospital.

15 “(D) ENSURING BONA FIDE INVEST-
16 MENT.—

17 “(i) Physician owners in the aggregate
18 do not own more than 40 percent of the
19 total value of the investment interests held
20 in the hospital or in an entity whose assets
21 include the hospital.

22 “(ii) The investment interest of any
23 individual physician owner does not exceed
24 2 percent of the total value of the invest-

1 ment interests held in the hospital or in an
2 entity whose assets include the hospital.

3 “(iii) Any ownership or investment in-
4 terests that the hospital offers to a physi-
5 cian owner are not offered on more favor-
6 able terms than the terms offered to a per-
7 son who is not a physician owner.

8 “(iv) The hospital does not directly or
9 indirectly provide loans or financing for
10 any physician owner investments in the
11 hospital.

12 “(v) The hospital does not directly or
13 indirectly guarantee a loan, make a pay-
14 ment toward a loan, or otherwise subsidize
15 a loan, for any individual physician owner
16 or group of physician owners that is re-
17 lated to acquiring any ownership interest
18 in the hospital.

19 “(vi) Investment returns are distrib-
20 uted to investors in the hospital in an
21 amount that is directly proportional to the
22 investment of capital by the physician
23 owner in the hospital.

24 “(vii) Physician owners do not receive,
25 directly or indirectly, any guaranteed re-

1 ceipt of or right to purchase other business
2 interests related to the hospital, including
3 the purchase or lease of any property
4 under the control of other investors in the
5 hospital or located near the premises of the
6 hospital.

7 “(viii) The hospital does not offer a
8 physician owner the opportunity to pur-
9 chase or lease any property under the con-
10 trol of the hospital or any other investor in
11 the hospital on more favorable terms than
12 the terms offered to an individual who is
13 not a physician owner.

14 “(E) PATIENT SAFETY.—

15 “(i) Insofar as the hospital admits a
16 patient and does not have any physician
17 available on the premises to provide serv-
18 ices during all hours in which the hospital
19 is providing services to such patient, before
20 admitting the patient—

21 “(I) the hospital discloses such
22 fact to a patient; and

23 “(II) following such disclosure,
24 the hospital receives from the patient

1 a signed acknowledgment that the pa-
2 tient understands such fact.

3 “(ii) The hospital has the capacity
4 to—

5 “(I) provide assessment and ini-
6 tial treatment for patients; and

7 “(II) refer and transfer patients
8 to hospitals with the capability to
9 treat the needs of the patient in-
10 volved.

11 “(2) PUBLICATION OF INFORMATION RE-
12 PORTED.—The Secretary shall publish, and update
13 on an annual basis, the information submitted by
14 hospitals under paragraph (1)(A)(i) on the public
15 Internet website of the Centers for Medicare & Med-
16 icaid Services.

17 “(3) COLLECTION OF OWNERSHIP AND INVEST-
18 MENT INFORMATION.—For purposes of clauses (i)
19 and (ii) of paragraph (1)(D), the Secretary shall col-
20 lect physician ownership and investment information
21 for each hospital as it existed on the date of the en-
22 actment of this subsection.

23 “(4) PHYSICIAN OWNER DEFINED.—For pur-
24 poses of this subsection, the term ‘physician owner’
25 means a physician (or an immediate family member

1 of such physician) with a direct or an indirect own-
2 ership interest in the hospital.”.

3 (b) ENFORCEMENT.—

4 (1) ENSURING COMPLIANCE.—The Secretary of
5 Health and Human Services shall establish policies
6 and procedures to ensure compliance with the re-
7 quirements described in such section 1877(i)(1) of
8 the Social Security Act, as added by subsection
9 (a)(3), beginning on the date such requirements first
10 apply. Such policies and procedures may include un-
11 announced site reviews of hospitals.

12 (2) AUDITS.—Beginning not later than 18
13 months after the date of the enactment of this Act,
14 the Secretary of Health and Human Services shall
15 conduct audits to determine if hospitals violate the
16 requirements referred to in paragraph (1).

17 **TITLE VII—PROVISIONS RELAT-**
18 **ING TO MEDICARE PARTS A**
19 **AND B**

20 **SEC. 701. HOME HEALTH PAYMENT UPDATE FOR 2008.**

21 Section 1895(b)(3)(B)(ii) of the Social Security Act
22 (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

23 (1) in subclause (IV) at the end, by striking
24 “and”;

1 (2) by redesignating subclause (V) as subclause
2 (VII); and

3 (3) by inserting after subclause (IV) the fol-
4 lowing new subclauses:

5 “(V) 2007, subject to clause (v),
6 the home health market basket per-
7 centage increase;

8 “(VI) 2008, subject to clause (v),
9 0 percent; and”.

10 **SEC. 702. 2-YEAR EXTENSION OF TEMPORARY MEDICARE**
11 **PAYMENT INCREASE FOR HOME HEALTH**
12 **SERVICES FURNISHED IN A RURAL AREA.**

13 Section 421 of the Medicare Prescription Drug, Im-
14 provement, and Modernization Act of 2003 (Public Law
15 108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as
16 amended by section 5201(b) of the Deficit Reduction Act
17 of 2005, is amended—

18 (1) in the heading, by striking “**ONE-YEAR**”
19 and inserting “**TEMPORARY**”; and

20 (2) in subsection (a), by striking “and episodes
21 and visits beginning on or after January 1, 2006,
22 and before January 1, 2007” and inserting “epi-
23 sodes and visits beginning on or after January 1,
24 2006, and before January 1, 2007, and episodes and

1 visits beginning on or after January 1, 2008, and
2 before January 1, 2010”.

3 **SEC. 703. EXTENSION OF MEDICARE SECONDARY PAYER**
4 **FOR BENEFICIARIES WITH END STAGE**
5 **RENAL DISEASE FOR LARGE GROUP PLANS.**

6 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
7 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
8 ed—

9 (1) by redesignating clauses (i) and (ii) as sub-
10 clauses (I) and (II), respectively, and indenting ac-
11 cordingly;

12 (2) by amending the text preceding subclause
13 (I), as so redesignated, to read as follows:

14 “(C) INDIVIDUALS WITH END STAGE
15 RENAL DISEASE.—

16 “(i) IN GENERAL.—A group health
17 plan (as defined in subparagraph (A)(v))—
18 ”;

19 (3) in the matter following subclause (II), as so
20 redesignated—

21 (A) by striking “clause (i)” and inserting
22 “subclause (I)”;

23 (B) by striking “clause (ii)” and inserting
24 “subclause (II)”;

1 (C) by striking “clauses (i) and (ii)” and
2 inserting “subclauses (I) and (II)”; and
3 (D) in the last sentence, by striking “Ef-
4 fective for items” and inserting “Subject to
5 clause (ii), effective for items”; and
6 (4) by adding at the end the following new
7 clause:

8 “(ii) SPECIAL RULE FOR LARGE
9 GROUP PLANS.—In applying clause (i) to
10 a large group health plan (as defined in
11 subparagraph (B)(iii)), with respect to pe-
12 riods beginning on or after the date that is
13 30 months prior to January 1, 2008, sub-
14 clauses (I) and (II) of such clause shall be
15 applied by substituting ‘42-month’ for ‘12-
16 month’ each place it appears.”.

17 **SEC. 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENTS**
18 **FOR NEVER EVENTS.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services (in this section referred to as the “Sec-
21 retary”) shall develop a plan (in this section referred to
22 as the “never events plan”) to implement, beginning in
23 fiscal year 2010, a policy to reduce or eliminate payments
24 under title XVIII of the Social Security Act for never
25 events.

1 (b) NEVER EVENT DEFINED.—For purposes of this
2 section, the term “never event” means an event involving
3 the delivery of (or failure to deliver) physicians’ services,
4 inpatient or outpatient hospital services, or facility serv-
5 ices furnished in an ambulatory surgical facility in which
6 there is an error in medical care that is clearly identifiable,
7 usually preventable, and serious in consequences to pa-
8 tients, and that indicates a deficiency in the safety and
9 process controls of the services furnished with respect to
10 the physician, hospital, or ambulatory surgical center in-
11 volved.

12 (c) PLAN DETAILS.—

13 (1) DEFINING NEVER EVENTS.—With respect
14 to criteria for identifying never events under the
15 never events plan, the Secretary should consider
16 whether the event meets the following characteris-
17 ties:

18 (A) CLEARLY IDENTIFIABLE.—The event
19 is clearly identifiable and measurable and fea-
20 sible to include in a reporting system for never
21 events.

22 (B) USUALLY PREVENTABLE.—The event
23 is usually preventable taking into consideration
24 that, because of the complexity of medical care,
25 certain medical events are not always avoidable.

1 (C) SERIOUS.—The event is serious and
2 could result in death or loss of a body part, dis-
3 ability, or more than transient loss of a body
4 function.

5 (D) DEFICIENCY IN SAFETY AND PROCESS
6 CONTROLS.—The event is indicative of a prob-
7 lem in safety systems and process controls used
8 by the physician, hospital, or ambulatory sur-
9 gical center involved and is indicative of the re-
10 liability of the quality of services provided by
11 the physician, hospital, or ambulatory surgical
12 center, respectively.

13 (2) IDENTIFICATION AND PAYMENT ISSUES.—
14 With respect to policies under the never events plan
15 for identifying and reducing (or eliminating) pay-
16 ment for never events, the Secretary shall consider—

17 (A) mechanisms used by hospitals and
18 physicians in reporting and coding of services
19 that would reliably identify never events; and

20 (B) modifications in billing and payment
21 mechanisms that would enable the Secretary to
22 efficiently and accurately reduce or eliminate
23 payments for never events.

24 (3) PRIORITIES.—Under the never events plan
25 the Secretary shall identify priorities regarding the

1 services to focus on and, among those, the never
2 events for which payments should be reduced or
3 eliminated.

4 (4) CONSULTATION.—In developing the never
5 events plan, the Secretary shall consult with affected
6 parties that are relevant to payment reductions in
7 response to never events.

8 (d) CONGRESSIONAL REPORT.—By not later than
9 June 1, 2008, the Secretary shall submit a report to Con-
10 gress on the never events plan developed under this sub-
11 section and shall include in the report recommendations
12 on specific methods for implementation of the plan on a
13 timely basis.

14 **SEC. 705. TREATMENT OF MEDICARE HOSPITAL RECLASSI-**
15 **FICATIONS.**

16 (a) EXTENDING CERTAIN MEDICARE HOSPITAL
17 WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL
18 YEAR 2009.—

19 (1) IN GENERAL.—Section 106(a) of the Medi-
20 care Improvements and Extension Act of 2006 (divi-
21 sion B of public Law 109–432) is amended by strik-
22 ing “September 30, 2007” and inserting “September
23 30, 2009”.

24 (2) SPECIAL EXCEPTION RECLASSIFICATIONS.—
25 The Secretary of Health and Human Services shall

1 extend for discharges occurring through September
2 30, 2009, the special exception reclassification made
3 under the authority of section 1886(d)(5)(I)(i) of
4 the Social Security Act (42 U.S.C.
5 1395ww(d)(5)(I)(i)) and contained in the final rule
6 promulgated by the Secretary in the Federal Reg-
7 ister on August 11, 2004 (69 Fed. Reg. 49105,
8 49107).

9 (b) DISREGARDING SECTION 508 HOSPITAL RECLAS-
10 SIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICA-
11 TIONS.—Section 508 of the Medicare Prescription Drug,
12 Improvement, and Modernization Act of 2003 (Public Law
13 108–173, 42 U.S.C. 1395ww note) is amended by adding
14 at the end the following new subsection:

15 “(g) DISREGARDING HOSPITAL RECLASSIFICATIONS
16 FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For
17 purposes of the reclassification of a group of hospitals in
18 a geographic area under section 1886(d), a hospital reclas-
19 sified under this section (including any such reclassifica-
20 tion which is extended under section 106(a) of the Medi-
21 care Improvements and Extension Act of 2006) shall not
22 be taken into account and shall not prevent the other hos-
23 pitals in such area from establishing such a group for such
24 purpose.”.

TITLE VIII—MEDICAID
Subtitle A—Protecting Existing
Coverage

SEC. 801. MODERNIZING TRANSITIONAL MEDICAID.

(a) TWO-YEAR EXTENSION.—

(1) IN GENERAL.—Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r-6(f)) are each amended by striking “September 30, 2003” and inserting “September 30, 2009”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on October 1, 2007.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 of the Social Security Act (42 U.S.C. 1396r-6) is amended—

(1) in subsection (a)(1), by inserting “but subject to paragraph (5)” after “Notwithstanding any other provision of this title”;

(2) by adding at the end of subsection (a) the following:

“(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months).

1 In the case of such an election, subsection (b) shall
2 not apply.”; and

3 (3) in subsection (b)(1), by inserting “but sub-
4 ject to subsection (a)(5)” after “Notwithstanding
5 any other provision of this title”.

6 (c) REMOVAL OF REQUIREMENT FOR PREVIOUS RE-
7 CEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of
8 such Act (42 U.S.C. 1396r-6(a)(1)), as amended by sub-
9 section (b)(1), is further amended—

10 (1) by inserting “subparagraph (B) and” before
11 “paragraph (5)”;

12 (2) by redesignating the matter after “RE-
13 QUIREMENT.—” as a subparagraph (A) with the
14 heading “IN GENERAL.—” and with the same inden-
15 tation as subparagraph (B) (as added by paragraph
16 (3)); and

17 (3) by adding at the end the following:

18 “(B) STATE OPTION TO WAIVE REQUIRE-
19 MENT FOR 3 MONTHS BEFORE RECEIPT OF
20 MEDICAL ASSISTANCE.—A State may, at its op-
21 tion, elect also to apply subparagraph (A) in
22 the case of a family that was receiving such aid
23 for fewer than three months or that had applied
24 for and was eligible for such aid for fewer than

1 3 months during the 6 immediately preceding
2 months described in such subparagraph.”.

3 (d) CMS REPORT ON ENROLLMENT AND PARTICIPA-
4 TION RATES UNDER TMA.—Section 1925 of such Act (42
5 U.S.C. 1396r-6), as amended by this section, is further
6 amended by adding at the end the following new sub-
7 section:

8 “(g) COLLECTION AND REPORTING OF PARTICIPA-
9 TION INFORMATION.—

10 “(1) COLLECTION OF INFORMATION FROM
11 STATES.—Each State shall collect and submit to the
12 Secretary (and make publicly available), in a format
13 specified by the Secretary, information on average
14 monthly enrollment and average monthly participa-
15 tion rates for adults and children under this section
16 and of the number and percentage of children who
17 become ineligible for medical assistance under this
18 section whose medical assistance is continued under
19 another eligibility category or who are enrolled under
20 the State’s child health plan under title XXI. Such
21 information shall be submitted at the same time and
22 frequency in which other enrollment information
23 under this title is submitted to the Secretary.

24 “(2) ANNUAL REPORTS TO CONGRESS.—Using
25 the information submitted under paragraph (1), the

1 Secretary shall submit to Congress annual reports
2 concerning enrollment and participation rates de-
3 scribed in such paragraph.”.

4 (e) EFFECTIVE DATE.—The amendments made by
5 subsections (b) through (d) shall take effect on the date
6 of the enactment of this Act.

7 **SEC. 802. FAMILY PLANNING SERVICES.**

8 (a) COVERAGE AS OPTIONAL CATEGORICALLY
9 NEEDY GROUP.—

10 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
11 of the Social Security Act (42 U.S.C.
12 1396a(a)(10)(A)(ii)) is amended—

13 (A) in subclause (XVIII), by striking “or”
14 at the end;

15 (B) in subclause (XIX), by adding “or” at
16 the end; and

17 (C) by adding at the end the following new
18 subclause:

19 “(XX) who are described in subsection (ee) (re-
20 lating to individuals who meet certain income stand-
21 ards);”.

22 (2) GROUP DESCRIBED.—Section 1902 of the
23 Social Security Act (42 U.S.C. 1396a), as amended
24 by section 112(c), is amended by adding at the end
25 the following new subsection:

1 “(ee)(1) Individuals described in this subsection are
2 individuals

3 “(A) whose income does not exceed an in-
4 come eligibility level established by the State
5 that does not exceed the highest income eligi-
6 bility level established under the State plan
7 under this title (or under its State child health
8 plan under title XXI) for pregnant women; and

9 “(B) who are not pregnant.

10 “(2) At the option of a State, individuals de-
11 scribed in this subsection may include individuals
12 who are determined to meet the eligibility require-
13 ments referred to in paragraph (1) under the terms,
14 conditions, and procedures applicable to making eli-
15 gibility determinations for medical assistance under
16 this title under a waiver to provide the benefits de-
17 scribed in clause (XV) of the matter following sub-
18 paragraph (G) of section 1902(a)(10) granted to the
19 State under section 1115 as of January 1, 2007.”.

20 (3) LIMITATION ON BENEFITS.—Section
21 1902(a)(10) of the Social Security Act (42 U.S.C.
22 1396a(a)(10)) is amended in the matter following
23 subparagraph (G)—

24 (A) by striking “and (XIV)” and inserting
25 “(XIV)”;

1 (B) by inserting “, and (XV) the medical
2 assistance made available to an individual de-
3 scribed in subsection (ee) shall be limited to
4 family planning services and supplies described
5 in section 1905(a)(4)(C) including medical di-
6 agnosis or treatment services that are provided
7 pursuant to a family planning service in a fam-
8 ily planning setting provided during the period
9 in which such an individual is eligible;” after
10 “cervical cancer”.

11 (4) CONFORMING AMENDMENTS.—Section
12 1905(a) of the Social Security Act (42 U.S.C.
13 1396d(a)) is amended in the matter preceding para-
14 graph (1)—

15 (A) in clause (xii), by striking “or” at the
16 end;

17 (B) in clause (xii), by adding “or” at the
18 end; and

19 (C) by inserting after clause (xiii) the fol-
20 lowing:

21 “(xiv) individuals described in section
22 1902(ee),”.

23 (b) PRESUMPTIVE ELIGIBILITY.—

1 (1) IN GENERAL.—Title XIX of the Social Se-
2 curity Act (42 U.S.C. 1396 et seq.) is amended by
3 inserting after section 1920B the following:

4 “PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING
5 SERVICES

6 “SEC. 1920C. (a) STATE OPTION.— State plan ap-
7 proved under section 1902 may provide for making med-
8 ical assistance available to an individual described in sec-
9 tion 1902(ee) (relating to individuals who meet certain in-
10 come eligibility standard) during a presumptive eligibility
11 period. In the case of an individual described in section
12 1902(ee), such medical assistance shall be limited to fam-
13 ily planning services and supplies described in
14 1905(a)(4)(C) and, at the State’s option, medical diag-
15 nosis or treatment services that are provided in conjune-
16 tion with a family planning service in a family planning
17 setting provided during the period in which such an indi-
18 vidual is eligible.

19 “(b) DEFINITIONS.—For purposes of this section:

20 “(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The
21 term ‘presumptive eligibility period’ means, with re-
22 spect to an individual described in subsection (a),
23 the period that—

24 “(A) begins with the date on which a
25 qualified entity determines, on the basis of pre-

1 liminary information, that the individual is de-
2 scribed in section 1902(ee); and

3 “(B) ends with (and includes) the earlier
4 of—

5 “(i) the day on which a determination
6 is made with respect to the eligibility of
7 such individual for services under the State
8 plan; or

9 “(ii) in the case of such an individual
10 who does not file an application by the last
11 day of the month following the month dur-
12 ing which the entity makes the determina-
13 tion referred to in subparagraph (A), such
14 last day.

15 “(2) QUALIFIED ENTITY.—

16 “(A) IN GENERAL.—Subject to subpara-
17 graph (B), the term ‘qualified entity’ means
18 any entity that—

19 “(i) is eligible for payments under a
20 State plan approved under this title; and

21 “(ii) is determined by the State agen-
22 cy to be capable of making determinations
23 of the type described in paragraph (1)(A).

24 “(B) RULE OF CONSTRUCTION.—Nothing
25 in this paragraph shall be construed as pre-

1 venting a State from limiting the classes of en-
2 tities that may become qualified entities in
3 order to prevent fraud and abuse.

4 “(c) ADMINISTRATION.—

5 “(1) IN GENERAL.—The State agency shall pro-
6 vide qualified entities with—

7 “(A) such forms as are necessary for an
8 application to be made by an individual de-
9 scribed in subsection (a) for medical assistance
10 under the State plan; and

11 “(B) information on how to assist such in-
12 dividuals in completing and filing such forms.

13 “(2) NOTIFICATION REQUIREMENTS.—A quali-
14 fied entity that determines under subsection
15 (b)(1)(A) that an individual described in subsection
16 (a) is presumptively eligible for medical assistance
17 under a State plan shall—

18 “(A) notify the State agency of the deter-
19 mination within 5 working days after the date
20 on which determination is made; and

21 “(B) inform such individual at the time
22 the determination is made that an application
23 for medical assistance is required to be made by
24 not later than the last day of the month fol-

1 lowing the month during which the determina-
2 tion is made.

3 “(3) APPLICATION FOR MEDICAL ASSIST-
4 ANCE.—In the case of an individual described in
5 subsection (a) who is determined by a qualified enti-
6 ty to be presumptively eligible for medical assistance
7 under a State plan, the individual shall apply for
8 medical assistance by not later than the last day of
9 the month following the month during which the de-
10 termination is made.

11 “(d) PAYMENT.—Notwithstanding any other provi-
12 sion of this title, medical assistance that—

13 “(1) is furnished to an individual described in
14 subsection (a)—

15 “(A) during a presumptive eligibility pe-
16 riod;

17 “(B) by a entity that is eligible for pay-
18 ments under the State plan; and

19 “(2) is included in the care and services covered
20 by the State plan, shall be treated as medical assist-
21 ance provided by such plan for purposes of clause
22 (4) of the first sentence of section 1905(b).”.

23 (2) CONFORMING AMENDMENTS.—

24 (A) Section 1902(a)(47) of the Social Se-
25 curity Act (42 U.S.C. 1396a(a)(47)) is amend-

1 ed by inserting before the semicolon at the end
2 the following: “and provide for making medical
3 assistance available to individuals described in
4 subsection (a) of section 1920C during a pre-
5 sumptive eligibility period in accordance with
6 such section.”.

7 (B) Section 1903(u)(1)(D)(v) of such Act
8 (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

9 (i) by striking “or for” and inserting
10 “, for”; and

11 (ii) by inserting before the period the
12 following: “, or for medical assistance pro-
13 vided to an individual described in sub-
14 section (a) of section 1920C during a pre-
15 sumptive eligibility period under such sec-
16 tion”.

17 (e) CLARIFICATION OF COVERAGE OF FAMILY PLAN-
18 NING SERVICES AND SUPPLIES.—Section 1937(b) of the
19 Social Security Act (42 U.S.C. 1396u-7(b)) is amended
20 by adding at the end the following:

21 “(5) COVERAGE OF FAMILY PLANNING SERV-
22 ICES AND SUPPLIES.—Notwithstanding the previous
23 provisions of this section, a State may not provide
24 for medical assistance through enrollment of an indi-
25 vidual with benchmark coverage or benchmark-equiv-

1 alent coverage under this section unless such cov-
2 erage includes for any individual described in section
3 1905(a)(4)(C), medical assistance for family plan-
4 ning services and supplies in accordance with such
5 section.”.

6 (f) EFFECTIVE DATE.—The amendments made by
7 this section take effect on October 1, 2007.

8 **SEC. 803. AUTHORITY TO CONTINUE PROVIDING ADULT**
9 **DAY HEALTH SERVICES APPROVED UNDER A**
10 **STATE MEDICAID PLAN.**

11 (a) IN GENERAL.—During the period described in
12 subsection (b), the Secretary of Health and Human Serv-
13 ices shall not—

14 (1) withhold, suspend, disallow, or otherwise
15 deny Federal financial participation under section
16 1903(a) of the Social Security Act (42 U.S.C.
17 1396b(a)) for the provision of adult day health care
18 services, day activity and health services, or adult
19 medical day care services, as defined under a State
20 Medicaid plan approved during or before 1994, dur-
21 ing such period if such services are provided con-
22 sistent with such definition and the requirements of
23 such plan; or

1 (2) withdraw Federal approval of any such
2 State plan or part thereof regarding the provision of
3 such services (by regulation or otherwise).

4 (b) PERIOD DESCRIBED.—The period described in
5 this subsection is the period that begins on November 3,
6 2005, and ends on March 1, 2009.

7 **SEC. 804. STATE OPTION TO PROTECT COMMUNITY**
8 **SPOUSES OF INDIVIDUALS WITH DISABIL-**
9 **ITIES.**

10 Section 1924(h)(1)(A) of the Social Security Act (42
11 U.S.C. 1396r-5(h)(1)(A)) is amended by striking “is de-
12 scribed in section 1902(a)(10)(A)(ii)(VI)” and inserting
13 “is being provided medical assistance for home and com-
14 munity-based services under subsection (c), (d), (e), (i),
15 or (j) of section 1915 or pursuant to section 1115”.

16 **SEC. 805. COUNTY MEDICAID HEALTH INSURING ORGANI-**
17 **ZATIONS .**

18 (a) IN GENERAL.—Section 9517(e)(3) of the Consoli-
19 dated Omnibus Budget Reconciliation Act of 1985 (42
20 U.S.C. 1396b note), as added by section 4734 of the Om-
21 nibus Budget Reconciliation Act of 1990 and as amended
22 by section 704 of the Medicare, Medicaid, and SCHIP
23 Benefits Improvement and Protection Act of 2000, is
24 amended—

(1) in subparagraph (A), by inserting “, in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County” after “described in subparagraph (B)”; and

(2) in subparagraph (C), by striking “14 percent” and inserting “16 percent”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

Subtitle B—Payments

SEC. 811. PAYMENTS FOR PUERTO RICO AND TERRITORIES.

(a) PAYMENT CEILING.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), by striking “paragraph (3)” and inserting “paragraphs (3) and (4)”; and

(2) by adding at the end the following new paragraph:

“(4) FISCAL YEARS 2009 THROUGH 2012 FOR CERTAIN INSULAR AREAS.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Is-

1 lands, and American Samoa for fiscal years 2009
2 through 2012 shall be increased by the following
3 amounts:

4 “(A) PUERTO RICO.—For Puerto Rico,
5 \$250,000,000 for fiscal year 2009,
6 \$350,000,000 for fiscal year 2010,
7 \$500,000,000 for fiscal year 2011, and
8 \$600,000,000 for fiscal year 2012.

9 “(B) VIRGIN ISLANDS.—For the Virgin Is-
10 lands, \$5,000,000 for each of fiscal years 2009
11 through 2012.

12 “(C) GUAM .—For Guam, \$5,000,000 for
13 each of fiscal years 2009 through 2012.

14 “(D) NORTHERN MARIANA ISLANDS.—For
15 the Northern Mariana Islands, \$4,000,000 for
16 each of fiscal years 2009 through 2012.

17 “(E) AMERICAN SAMOA.—For American
18 Samoa, \$4,000,000 for each of fiscal years
19 2009 through 2012.

20 Such amounts shall not be taken into account in ap-
21 plying paragraph (2) for fiscal years 2009 through
22 2012 but shall be taken into account in applying
23 such paragraph for fiscal year 2013 and subsequent
24 fiscal years.”.

1 (b) REMOVAL OF FEDERAL MATCHING PAYMENTS
2 FOR IMPROVING DATA REPORTING SYSTEMS FROM THE
3 OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER
4 TITLE XIX.—Such section is further amended by adding
5 at the end the following new paragraph:

6 “(5) EXCLUSION OF CERTAIN EXPENDITURES
7 FROM PAYMENT LIMITS.— With respect to fiscal
8 year 2008 and each fiscal year thereafter, if Puerto
9 Rico, the Virgin Islands, Guam, the Northern Mar-
10 iana Islands, or American Samoa qualify for a pay-
11 ment under subparagraph (A)(i) or (B) of section
12 1903(a)(3) for a calendar quarter of such fiscal year
13 with respect to expenditures for improvements in
14 data reporting systems described in such subpara-
15 graph, the limitation on expenditures under title
16 XIX for such commonwealth or territory otherwise
17 determined under subsection (f) and this subsection
18 for such fiscal year shall be determined without re-
19 gard to payment for such expenditures.”.

20 **SEC. 812. MEDICAID DRUG REBATE.**

21 (a) BRAND.—Paragraph (1)(B)(i) of section 1927(e)
22 of the Social Security Act (42 U.S.C. 1396r-8(c)) is
23 amended—

24 (1) by striking “and” at the end of subclause
25 (IV);

1 (2) in subclause (V)—

2 (A) by inserting “and before January 1,
3 2008,” after “December 31, 1995”; and

4 (B) by striking the period at the end and
5 inserting “; and”; and

6 (3) by adding at the end the following new sub-
7 clause:

8 “(VI) after December 31, 2007,
9 is 20.1 percent.”.

10 (b) PBMS TO BEST PRICE DEFINITION.—

11 (1) IN GENERAL.—Section 1927(c)(1)(C)(ii)(I)
12 of the Social Security Act (42 U.S.C. 1396r-
13 8(c)(1)(C)(ii)(I)) is amended—

14 (A) by striking “and” before “rebates”;
15 and

16 (B) by inserting before the semicolon at
17 the end the following: “, and rebates, discounts,
18 and other price concessions to pharmaceutical
19 benefit managers (PBMs)”.

20 (2) EFFECTIVE DATE.—The amendments made
21 by paragraph (1) shall apply to calendar quarters
22 beginning on or after January 1, 2008.

1 **SEC. 813. ADJUSTMENT IN COMPUTATION OF MEDICAID**
2 **FMAP TO DISREGARD AN EXTRAORDINARY**
3 **EMPLOYER PENSION CONTRIBUTION.**

4 (a) IN GENERAL.—Only for purposes of computing
5 the Federal medical assistance percentage under section
6 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))
7 for a State for a fiscal year (beginning with fiscal year
8 2006), any significantly disproportionate employer pension
9 contribution described in subsection (b) shall be dis-
10 regarded in computing the per capita income of such
11 State, but shall not be disregarded in computing the per
12 capita income for the continental United States (and Alas-
13 ka) and Hawaii.

14 (b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER
15 PENSION CONTRIBUTION.—For purposes of subsection
16 (a), a significantly disproportionate employer pension con-
17 tribution described in this subsection with respect to a
18 State for a fiscal year is an employer contribution towards
19 pensions that is allocated to such State for a period if the
20 aggregate amount so allocated exceeds 25 percent of the
21 total increase in personal income in that State for the pe-
22 riod involved.

23 **SEC. 814. MORATORIUM ON CERTAIN PAYMENT RESTRIC-**
24 **TIONS.**

25 Notwithstanding any other provision of law, the Sec-
26 retary of Health and Human Services shall not, prior to

1 the date that is 1 year after the date of enactment of this
2 Act, take any action (through promulgation of regulation,
3 issuance of regulatory guidance, use of federal payment
4 audit procedures, or other administrative action, policy, or
5 practice, including a Medical Assistance Manual trans-
6 mittal or letter to State Medicaid directors) to restrict cov-
7 erage or payment under title XIX of the Social Security
8 Act for rehabilitation services, or school-based administra-
9 tion, transportation, or medical services if such restric-
10 tions are more restrictive in any aspect than those applied
11 to such coverage or payment as of July 1, 2007.

12 **SEC. 815. TENNESSEE DSH.**

13 The DSH allotments for Tennessee for each fiscal
14 year beginning with fiscal year 2008 under subsection
15 (f)(3) of section 1923 of the Social Security Act (42
16 U.S.C. 1396r-4) are deemed to be \$30,000,000. The
17 Secretary of Health and Human Services may impose a
18 limitation on the total amount of payments made to hos-
19 pitals under the TennCare Section 1115 waiver only to
20 the extent that such limitation is necessary to ensure that
21 a hospital does not receive payment in excess of the
22 amounts described in subsection (f) of such section or as
23 necessary to ensure that the waiver remains budget neu-
24 tral.

1 **SEC. 816. CLARIFICATION TREATMENT OF REGIONAL MED-**
2 **ICAL CENTER.**

3 (a) IN GENERAL.—Nothing in section 1903(w) of the
4 Social Security Act (42 U.S.C. 1396b(w)) shall be con-
5 strued by the Secretary of Health and Human Services
6 as prohibiting a State's use of funds as the non-Federal
7 share of expenditures under title XIX of such Act where
8 such funds are transferred from or certified by a publicly-
9 owned regional medical center located in another State
10 and described in subsection (b), so long as the Secretary
11 determines that such use of funds is proper and in the
12 interest of the program under title XIX.

13 (b) CENTER DESCRIBED.—A center described in this
14 subsection is a publicly-owned regional medical center
15 that—

16 (1) provides level 1 trauma and burn care serv-
17 ices;

18 (2) provides level 3 neonatal care services;

19 (3) is obligated to serve all patients, regardless
20 of ability to pay;

21 (4) is located within a Standard Metropolitan
22 Statistical Area (SMSA) that includes at least 3
23 States;

24 (5) provides services as a tertiary care provider
25 for patients residing within a 125-mile radius; and

1 (6) meets the criteria for a disproportionate
2 share hospital under section 1923 of such Act (42
3 U.S.C. 1396r-4) in at least one State other than the
4 State in which the center is located.

5 **Subtitle C—Miscellaneous**

6 **SEC. 821. DEMONSTRATION PROJECT FOR EMPLOYER BUY-**
7 **IN.**

8 Title XXI of the Social Security Act, as amended by
9 section 115(a)(1), is further amended by adding at the
10 end the following new section:

11 **“SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER**
12 **BUY-IN.**

13 “(a) AUTHORITY.—

14 “(1) IN GENERAL.—The Secretary shall estab-
15 lish a demonstration project under which up to 10
16 States (each referred to in this section as a ‘partici-
17 pating State’) that meets the conditions of para-
18 graph (2) may provide, under its State child health
19 plan (notwithstanding section 2102(b)(3)(C)) for a
20 period of 5 years, for child health assistance in rela-
21 tion to family coverage described in subsection (d)
22 for children who would be targeted low-income chil-
23 dren but for coverage as beneficiaries under a group
24 health plan as the children of participants by virtue

1 of a qualifying employer's contribution under sub-
2 section (b)(2). :

3 “(2) CONDITIONS.—The conditions described in
4 this paragraph for a State are as follows:

5 “(A) NO WAITING LISTS.—The State does
6 not impose any waiting list, enrollment cap, or
7 similar limitation on enrollment of targeted low-
8 income children under the State child health
9 plan.

10 “(B) ELIGIBILITY OF ALL CHILDREN
11 UNDER 200 PERCENT OF POVERTY LINE.—The
12 State is applying an income eligibility level
13 under section 2110(b)(1)(B)(ii)(I) that is at
14 least 200 percent of the poverty line.

15 “(3) QUALIFYING EMPLOYER DEFINED.—In
16 this section, the term ‘qualifying employer’ means an
17 employer that has a majority of its workforce com-
18 posed of full-time workers with family incomes rea-
19 sonably estimated by the employer (based on wage
20 information available to the employer) at or below
21 200 percent of the poverty line. In applying the pre-
22 vious sentence, two part-time workers shall be treat-
23 ed as a single full-time worker.

24 “(b) FUNDING.—A demonstration project under this
25 section in a participating State shall be funded, with re-

1 spect to assistance provided to children described in sub-
2 section (a)(1), consistent with the following:

3 “(1) LIMITED FAMILY CONTRIBUTION.—The
4 family involved shall be responsible for providing
5 payment towards the premium for such assistance of
6 such amount as the State may specify, except that
7 the limitations on cost-sharing (including premiums)
8 under paragraphs (2) and (3) of section 2103(e)
9 shall apply to all cost-sharing of such family under
10 this section.

11 “(2) MINIMUM EMPLOYER CONTRIBUTION.—
12 The qualifying employer involved shall be responsible
13 for providing payment to the State child health plan
14 in the State of at least 50 percent of the portion of
15 the cost (as determined by the State) of the family
16 coverage in which the employer is enrolling the fam-
17 ily that exceeds the amount of the family contribu-
18 tion under paragraph (1) applied towards such cov-
19 erage.

20 “(3) LIMITATION ON FEDERAL FINANCIAL PAR-
21 TICIPATION.—In no case shall the Federal financial
22 participation under section 2105 with respect to a
23 demonstration project under this section be made for
24 any portion of the costs of family coverage described
25 in subsection (d) (including the costs of administra-

tion of such coverage) that are not attributable to children described in subsection (a)(1).

“(c) UNIFORM ELIGIBILITY RULES.—In providing assistance under a demonstration project under this section—

“(1) a State shall establish uniform rules of eligibility for families to participate; and

“(2) a State shall not permit a qualifying employer to select, within those families that meet such eligibility rules, which families may participate.

“(d) TERMS AND CONDITIONS.—The family coverage offered to families of qualifying employers under a demonstration project under this section in a State shall be the same as the coverage and benefits provided under the State child health plan in the State for targeted low-income children with the highest family income level permitted.”.

SEC. 822. DIABETES GRANTS.

Section 2104 of the Social Security Act (42 U.C.C 1397dd), as amended by section 101, is further amended—

(1) in subsection (a)(11), by inserting before the period at the end the following: “plus for fiscal year 2009 the total of the amount specified in subsection (j)”; and

1 (2) by adding at the end the following new sub-
2 section:

3 “(j) FUNDING FOR DIABETES GRANTS.—From the
4 amounts appropriated under subsection (a)(11), for fiscal
5 year 2009 from the amounts—

6 “(1) \$150,000,000 is hereby transferred and
7 made available in such fiscal year for grants under
8 section 330B of the Public Health Service Act; and

9 “(2) \$150,000,000 is hereby transferred and
10 made available in such fiscal year for grants under
11 section 330C of such Act.”.

12 **SEC. 823. TECHNICAL CORRECTION.**

13 (a) CORRECTION OF REFERENCE TO CHILDREN IN
14 FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—
15 Section 1937(a)(2)(B)(viii) of the Social Security Act (42
16 U.S.C. 1396u-7(a)(2)(B) is amended by striking “aid or
17 assistance is made available under part B of title IV to
18 children in foster care” and inserting “child welfare serv-
19 ices are made available under part B of title IV on the
20 basis of being a child in foster care”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall take effect as if included in the
23 amendment made by section 6044(a) of the Deficit Reduc-
24 tion Act of 2005.

1 **TITLE IX—MISCELLANEOUS**

2 **SEC. 901. MEDICARE PAYMENT ADVISORY COMMISSION**
3 **STATUS.**

4 Section 1805(a) of the Social Security Act (42 U.S.C.
5 1395b-6(a)) is amended by inserting “as an agency of
6 Congress” after “established”.

7 **SEC. 902. REPEAL OF TRIGGER PROVISION.**

8 Subtitle A of title VIII of the Medicare Prescription
9 Drug, Improvement, and Modernization Act of 2003 (Pub-
10 lic Law 108–173) is repealed and the provisions of law
11 amended by such subtitle are restored as if such subtitle
12 had never been enacted.

13 **SEC. 903. REPEAL OF COMPARATIVE COST ADJUSTMENT**
14 **(CCA) PROGRAM.**

15 Section 1860C–1 of the Social Security Act (42
16 U.S.C. 1395w-29), as added by section 241(a) of the
17 Medicare Prescription Drug, Improvement, and Mod-
18 ernization Act of 2003 (Public Law 108–173), is repealed.

19 **SEC. 904. COMPARATIVE EFFECTIVENESS RESEARCH.**

20 (a) IN GENERAL.—Part A of title XVIII of the Social
21 Security Act is amended by adding at the end the fol-
22 lowing new section:

23 “COMPARATIVE EFFECTIVENESS RESEARCH

24 “SEC. 1822. (a) CENTER FOR COMPARATIVE EFFEC-
25 TIVENESS RESEARCH ESTABLISHED.—

1 “(1) IN GENERAL.—The Secretary shall estab-
2 lish within the Agency of Healthcare Research and
3 Quality a Center for Comparative Effectiveness Re-
4 search (in this section referred to as the ‘Center’) to
5 conduct, support, and synthesize research (including
6 research conducted or supported under section 1013
7 of the Medicare Prescription Drug, Improvement,
8 and Modernization Act of 2003) with respect to the
9 outcomes, effectiveness, and appropriateness of
10 health care services and procedures in order to iden-
11 tify the manner in which diseases, disorders, and
12 other health conditions can most effectively and ap-
13 propriately be prevented, diagnosed, treated, and
14 managed clinically.

15 “(2) DUTIES.—The Center shall—

16 “(A) conduct, support, and synthesize re-
17 search relevant to the comparative clinical effec-
18 tiveness of the full spectrum of health care
19 treatments, including pharmaceuticals, medical
20 devices, medical and surgical procedures, and
21 other medical interventions;

22 “(B) conduct and support systematic re-
23 views of clinical research, including original re-
24 search conducted subsequent to the date of the
25 enactment of this section;

1 “(C) use methodologies such as random-
2 ized controlled clinical trials as well as other
3 various types of clinical research, such as obser-
4 vational studies;

5 “(D) submit to the Comparative Effective-
6 ness Research Commission, the Secretary, and
7 Congress appropriate relevant reports described
8 in subsection (d)(2);

9 “(E) encourage, as appropriate, the devel-
10 opment and use of clinical registries and the de-
11 velopment of clinical effectiveness research data
12 networks from electronic health records, post
13 marketing drug and medical device surveillance
14 efforts, and other forms of electronic health
15 data; and

16 “(F) not later than 180 days after the
17 date of the enactment of this section, develop
18 methodological standards to be used when con-
19 ducting studies of comparative clinical effective-
20 ness and value (and procedures for use of such
21 standards) in order to help ensure accurate and
22 effective comparisons and update such stand-
23 ards at least biennially.

24 “(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS
25 RESEARCH COMMISSION.—

1 “(1) IN GENERAL.—The Secretary shall estab-
2 lish an independent Comparative Effectiveness Re-
3 search Commission (in this section referred to as the
4 ‘Commission’) to oversee and evaluate the activities
5 carried out by the Center under subsection (a) to en-
6 sure such activities result in highly credible research
7 and information resulting from such research.

8 “(2) DUTIES.—The Commission shall—

9 “(A) determine national priorities for re-
10 search described in subsection (a) and in mak-
11 ing such determinations consult with patients
12 and health care providers and payers;

13 “(B) monitor the appropriateness of use of
14 the CERTF described in subsection (f) with re-
15 spect to the timely production of comparative
16 effectiveness research determined to be a na-
17 tional priority under subparagraph (A);

18 “(C) identify highly credible research
19 methods and standards of evidence for such re-
20 search to be considered by the Center;

21 “(D) review and approve the methodo-
22 logical standards (and updates to such stand-
23 ards) developed by the Center under subsection
24 (a)(2)(F);

1 “(E) enter into an arrangement under
2 which the Institute of Medicine of the National
3 Academy of Sciences shall conduct an evalua-
4 tion and report on standards of evidence for
5 such research;

6 “(F) support forums to increase stake-
7 holder awareness and permit stakeholder feed-
8 back on the efforts of the Agency of Healthcare
9 Research and Quality to advance methods and
10 standards that promote highly credible re-
11 search;

12 “(G) make recommendations for public
13 data access policies of the Center that would
14 allow for access of such data by the public while
15 ensuring the information produced from re-
16 search involved is timely and credible;

17 “(H) appoint a clinical perspective advisory
18 panel for each research priority determined
19 under subparagraph (A), which shall frame the
20 specific research inquiry to be examined with
21 respect to such priority to ensure that the infor-
22 mation produced from such research is clinically
23 relevant to decisions made by clinicians and pa-
24 tients at the point of care;

1 “(I) make recommendations for the pri-
2 ority for periodic reviews of previous compara-
3 tive effectiveness research and studies con-
4 ducted by the Center under subsection (a);

5 “(J) routinely review processes of the Cen-
6 ter with respect to such research to confirm
7 that the information produced by such research
8 is objective, credible, consistent with standards
9 of evidence established under this section, and
10 developed through a transparent process that
11 includes consultations with appropriate stake-
12 holders;

13 “(K) at least annually, provide guidance or
14 recommendations to health care providers and
15 consumers for the use of information on the
16 comparative effectiveness of health care services
17 by consumers, providers (as defined for pur-
18 poses of regulations promulgated under section
19 264(c) of the Health Insurance Portability and
20 Accountability Act of 1996) and public and pri-
21 vate purchasers;

22 “(L) make recommendations for a strategy
23 to disseminate the findings of research con-
24 ducted and supported under this section that
25 enables clinicians to improve performance, con-

1 sumers to make more informed health care de-
2 cisions, and payers to set medical policies that
3 improve quality and value;

4 “(M) provide for the public disclosure of
5 relevant reports described in subsection (d)(2);
6 and

7 “(N) submit to Congress an annual report
8 on the progress of the Center in achieving na-
9 tional priorities determined under subparagraph
10 (A) for the provision of credible comparative ef-
11 fectiveness information produced from such re-
12 search to all interested parties.

13 “(3) COMPOSITION OF COMMISSION.—

14 “(A) IN GENERAL.—The members of the
15 Commission shall consist of—

16 “(i) the Director of the Agency for
17 Healthcare Research and Quality;

18 “(ii) the Chief Medical Officer of the
19 Centers for Medicare & Medicaid
20 Services; and

21 “(iii) up to 15 additional members
22 who shall represent broad constituencies of
23 stakeholders including clinicians, patients,
24 researchers, third-party payers, consumers

1 of Federal and State beneficiary programs.

2 .

3 “(B) QUALIFICATIONS.—

4 “(i) DIVERSE REPRESENTATION OF
5 PERSPECTIVES.—The members of the
6 Commission shall represent a broad range
7 of perspectives and shall collectively have
8 experience in the following areas:

9 “(I) Epidemiology.

10 “(II) Health services research.

11 “(III) Bioethics.

12 “(IV) Decision sciences.

13 “(V) Economics.

14 “(ii) DIVERSE REPRESENTATION OF
15 HEALTH CARE COMMUNITY.—At least one
16 member shall represent each of the fol-
17 lowing health care communities:

18 “(I) Consumers.

19 “(II) Practicing physicians, in-
20 cluding surgeons.

21 “(III) Employers.

22 “(IV) Public payers.

23 “(V) Insurance plans.

1 “(VI) Clinical researchers who
2 conduct research on behalf of pharma-
3 ceutical or device manufacturers.

4 “(4) APPOINTMENT.—The Comptroller General
5 of the United States, in consultation with the chairs
6 of the committees of jurisdiction of the House of
7 Representatives and the Senate, shall appoint the
8 members of the Commission.

9 “(5) CHAIRMAN; VICE CHAIRMAN.—The Comp-
10 troller General of the United States shall designate
11 a member of the Commission, at the time of ap-
12 pointment of the member, as Chairman and a mem-
13 ber as Vice Chairman for that term of appointment,
14 except that in the case of vacancy of the Chairman-
15 ship or Vice Chairmanship, the Comptroller General
16 may designate another member for the remainder of
17 that member’s term.

18 “(6) TERMS.—

19 “(A) IN GENERAL.—Except as provided in
20 subparagraph (B), each member of the Com-
21 mission shall be appointed for a term of 4
22 years.

23 “(B) TERMS OF INITIAL APPOINTEES.—Of
24 the members first appointed—

1 “(i) 10 shall be appointed for a term
2 of 4 years; and

3 “(ii) 9 shall be appointed for a term
4 of 3 years.

5 “(7) COORDINATION.—To enhance effectiveness
6 and coordination, the Comptroller General is encour-
7 aged, to the greatest extent possible, to seek coordi-
8 nation between the Commission and the National
9 Advisory Council of the Agency for Healthcare Re-
10 search and Quality.

11 “(8) CONFLICTS OF INTEREST.—In appointing
12 the members of the Commission or a clinical per-
13 spective advisory panel described in paragraph
14 (2)(G), the Comptroller General of the United States
15 or the Commission, respectively, shall take into con-
16 sideration any financial conflicts of interest.

17 “(9) COMPENSATION.—While serving on the
18 business of the Commission (including traveltime), a
19 member of the Commission shall be entitled to com-
20 pensation at the per diem equivalent of the rate pro-
21 vided for level IV of the Executive Schedule under
22 section 5315 of title 5, United States Code; and
23 while so serving away from home and the member’s
24 regular place of business, a member may be allowed

1 travel expenses, as authorized by the Director of the
2 Commission.

3 “(10) AVAILABILITY OF REPORTS.—The Com-
4 mission shall transmit to the Secretary a copy of
5 each report submitted under this subsection and
6 shall make such reports available to the public.

7 “(11) DIRECTOR AND STAFF; EXPERTS AND
8 CONSULTANTS.—Subject to such review as the Sec-
9 retary, in consultation with the Comptroller General
10 deems necessary to assure the efficient administra-
11 tion of the Commission, the Commission may—

12 “(A) employ and fix the compensation of
13 an Executive Director (subject to the approval
14 of the Secretary, in consultation with the
15 Comptroller General) and such other personnel
16 as may be necessary to carry out its duties
17 (without regard to the provisions of title 5,
18 United States Code, governing appointments in
19 the competitive service);

20 “(B) seek such assistance and support as
21 may be required in the performance of its du-
22 ties from appropriate Federal departments and
23 agencies;

24 “(C) enter into contracts or make other ar-
25 rangements, as may be necessary for the con-

1 duct of the work of the Commission (without
2 regard to section 3709 of the Revised Statutes
3 (41 U.S.C. 5));

4 “(D) make advance, progress, and other
5 payments which relate to the work of the Com-
6 mission;

7 “(E) provide transportation and subsist-
8 ence for persons serving without compensation;
9 and

10 “(F) prescribe such rules and regulations
11 as it deems necessary with respect to the inter-
12 nal organization and operation of the Commis-
13 sion.

14 “(12) POWERS.—

15 “(A) OBTAINING OFFICIAL DATA.—The
16 Commission may secure directly from any de-
17 partment or agency of the United States infor-
18 mation necessary to enable it to carry out this
19 section. Upon request of the Executive Director,
20 the head of that department or agency shall
21 furnish that information to the Commission on
22 an agreed upon schedule.

23 “(B) DATA COLLECTION.—In order to
24 carry out its functions, the Commission shall—

1 “(i) utilize existing information, both
2 published and unpublished, where possible,
3 collected and assessed either by its own
4 staff or under other arrangements made in
5 accordance with this section,

6 “(ii) carry out, or award grants or
7 contracts for, original research and experi-
8 mentation, where existing information is
9 inadequate, and

10 “(iii) adopt procedures allowing any
11 interested party to submit information for
12 the Commission’s use in making reports
13 and recommendations.

14 “(C) ACCESS OF GAO TO INFORMATION.—
15 The Comptroller General shall have unrestricted
16 access to all deliberations, records, and non-
17 proprietary data of the Commission, imme-
18 diately upon request.

19 “(D) PERIODIC AUDIT.—The Commission
20 shall be subject to periodic audit by the Comp-
21 troller General.

22 “(e) RESEARCH REQUIREMENTS.—Any research con-
23 ducted, supported, or synthesized under this section shall
24 meet the following requirements:

1 “(1) ENSURING TRANSPARENCY, CREDIBILITY,
2 AND ACCESS.—

3 “(A) The establishment of the agenda and
4 conduct of the research shall be insulated from
5 inappropriate political or stakeholder influence.

6 “(B) Methods of conducting such research
7 shall be scientifically based.

8 “(C) All aspects of the prioritization of re-
9 search, conduct of the research, and develop-
10 ment of conclusions based on the research shall
11 be transparent to all stakeholders.

12 “(D) The process and methods for con-
13 ducting such research shall be publicly docu-
14 mented and available to all stakeholders.

15 “(E) Throughout the process of such re-
16 search, the Center shall provide opportunities
17 for all stakeholders involved to review and pro-
18 vide comment on the methods and findings of
19 such research.

20 “(2) USE OF CLINICAL PERSPECTIVE ADVISORY
21 PANELS.—The research shall meet a national re-
22 search priority determined under subsection
23 (b)(2)(A) and shall examine the specific research in-
24 quiry framed by the clinical perspective advisory
25 panel for the national research priority.

1 “(3) STAKEHOLDER INPUT.—The priorities of
2 the research, the research, and the dissemination of
3 the research shall involve the consultation of pa-
4 tients, health care providers, and health care con-
5 sumer representatives through transparent mecha-
6 nisms recommended by the Commission.

7 “(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-
8 NESS INFORMATION.—

9 “(1) IN GENERAL.—Not later than 90 days
10 after receipt by the Center or Commission, as appli-
11 cable, of a relevant report described in paragraph
12 (2) made by the Center, Commission, or clinical per-
13 spective advisory panel under this section, appro-
14 priate information contained in such report shall be
15 posted on the official public Internet site of the Cen-
16 ter and of the Commission, as applicable.

17 “(2) RELEVANT REPORTS DESCRIBED.—For
18 purposes of this section, a relevant report is each of
19 the following submitted by a grantee or contractor
20 of the Center:

21 “(A) An interim progress report.

22 “(B) A draft final comparative effective-
23 ness review.

1 “(C) A final progress report on new re-
2 search submitted for publication by a peer re-
3 view journal.

4 “(D) Stakeholder comments.

5 “(E) A final report.

6 “(3) ACCESS BY CONGRESS AND THE COMMIS-
7 SION TO THE CENTER’S INFORMATION.—Congress
8 and the Commission shall each have unrestricted ac-
9 cess to all deliberations, records, and nonproprietary
10 data of the Center, immediately upon request.

11 “(e) DISSEMINATION AND INCORPORATION OF COM-
12 PARATIVE EFFECTIVENESS INFORMATION.—

13 “(1) DISSEMINATION.—The Center shall pro-
14 vide for the dissemination of appropriate findings
15 produced by research supported, conducted, or syn-
16 thesized under this section to health care providers,
17 patients, vendors of health information technology
18 focused on clinical decision support, appropriate pro-
19 fessional associations, and Federal and private
20 health plans.

21 “(2) INCORPORATION.—The Center shall assist
22 users of health information technology focused on
23 clinical decision support to promote the timely incor-
24 poration of the findings described in paragraph (1)

1 into clinical practices and to promote the ease of use
2 of such incorporation.

3 “(f) REPORTS TO CONGRESS.—

4 “(1) ANNUAL REPORTS.—Beginning not later
5 than one year after the date of the enactment of this
6 section, the Director of the Agency of Healthcare
7 Research and Quality and the Center for Compara-
8 tive Effectiveness Research shall submit to Congress
9 an annual report on the activities of the Center and
10 the Commission, as well as the research, conducted
11 under this section.

12 “(2) RECOMMENDATION FOR FAIR SHARE PER
13 CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Be-
14 ginning not later than December 31, 2009, the Sec-
15 retary shall submit to Congress an annual rec-
16 ommendation for a fair share per capita amount de-
17 scribed in subsection (c)(1) of section 9511 of the
18 Internal Revenue Code of 1986 for purposes of
19 funding the CERTF under such section.

20 “(3) ANALYSIS AND REVIEW.—Not later than
21 December 31, 2011, the Secretary, in consultation
22 with the Commission, shall submit to Congress a re-
23 port on all activities conducted or supported under
24 this section as of such date. Such report shall in-
25 clude an evaluation of the return on investment re-

1 sulting from such activities, the overall costs of such
2 activities, and an analysis of the backlog of any re-
3 search proposals approved by the Commission but
4 not funded. Such report shall also address whether
5 Congress should expand the responsibilities of the
6 Center and of the Commission to include studies of
7 the effectiveness of various aspects of the health care
8 delivery system, including health plans and delivery
9 models, such as health plan features, benefit designs
10 and performance, and the ways in which health serv-
11 ices are organized, managed, and delivered.

12 “(g) COORDINATING COUNCIL FOR HEALTH SERV-
13 ICES RESEARCH.—

14 “(1) ESTABLISHMENT.—The Secretary shall es-
15 tablish a permanent council (in this section referred
16 to as the ‘Council’) for the purpose of—

17 “(A) assisting the offices and agencies of
18 the Department of Health and Human Services,
19 the Department of Veterans Affairs, the De-
20 partment of Defense, and any other Federal de-
21 partment or agency to coordinate the conduct
22 or support of health services research; and

23 “(B) advising the President and Congress
24 on—

1 “(i) the national health services re-
2 search agenda;

3 “(ii) strategies with respect to infra-
4 structure needs of health services research;
5 and

6 “(iii) appropriate organizational ex-
7 penditures in health services research by
8 relevant Federal departments and agen-
9 cies.

10 “(2) MEMBERSHIP.—

11 “(A) NUMBER AND APPOINTMENT.—The
12 Council shall be composed of 20 members. One
13 member shall be the Director of the Agency for
14 Healthcare Research and Quality. The Director
15 shall appoint the other members not later than
16 30 days after the enactment of this Act.

17 “(B) TERMS.—

18 “(i) IN GENERAL.—Except as pro-
19 vided in clause (ii), each member of the
20 Council shall be appointed for a term of 4
21 years.

22 “(ii) TERMS OF INITIAL AP-
23 POINTEES.—Of the members first ap-
24 pointed—

1 “(I) 8 shall be appointed for a
2 term of 4 years; and

3 “(II) 7 shall be appointed for a
4 term of 3 years.

5 “(iii) VACANCIES.—Any vacancies
6 shall not affect the power and duties of the
7 Council and shall be filled in the same
8 manner as the original appointment.

9 “(C) QUALIFICATIONS.—

10 “(i) IN GENERAL.—The members of
11 the Council shall include one senior official
12 from each of the following agencies:

13 “(I) The Veterans Health Ad-
14 ministration.

15 “(II) The Department of Defense
16 Military Health Care System.

17 “(III) The Centers for Disease
18 Control and Prevention.

19 “(IV) The National Center for
20 Health Statistics.

21 “(V) The National Institutes of
22 Health.

23 “(VI) The Center for Medicare
24 & Medicaid Services.

1 “(VII) The Federal Employees
2 Health Benefits Program.

3 “(ii) NATIONAL, PHILANTHROPIC
4 FOUNDATIONS.—The members of the
5 Council shall include 4 senior leaders from
6 major national, philanthropic foundations
7 that fund and use health services research.

8 “(iii) STAKEHOLDERS.—The remain-
9 ing members of the Council shall be rep-
10 resentatives of other stakeholders in health
11 services research, including private pur-
12 chasers, health plans, hospitals and other
13 health facilities, and health consumer
14 groups.

15 “(3) ANNUAL REPORT.—The Council shall sub-
16 mit to Congress an annual report on the progress of
17 the implementation of the national health services
18 research agenda.

19 “(h) FUNDING OF COMPARATIVE EFFECTIVENESS
20 RESEARCH.—For fiscal year 2009 and each subsequent
21 fiscal year, amounts in the Comparative Effectiveness Re-
22 search Trust Fund (referred to in this section as the
23 ‘CERTF’) under section 9511 of the Internal Revenue
24 Code of 1986 shall be available to the Secretary to carry
25 out this section.”.

1 (b) COMPARATIVE EFFECTIVENESS RESEARCH
2 TRUST FUND; FINANCING FOR TRUST FUND.—

3 (1) ESTABLISHMENT OF TRUST FUND.—

4 (A) IN GENERAL.—Subchapter A of chap-
5 ter 98 of the Internal Revenue Code of 1986
6 (relating to trust fund code) is amended by
7 adding at the end the following new section:

8 **“SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**
9 **RESEARCH TRUST FUND.**

10 “(a) CREATION OF TRUST FUND.—There is estab-
11 lished in the Treasury of the United States a trust fund
12 to be known as the ‘Health Care Comparative Effective-
13 ness Research Trust Fund’ (hereinafter in this section re-
14 ferred to as the ‘CERTF’), consisting of such amounts
15 as may be appropriated or credited to such Trust Fund
16 as provided in this section and section 9602(b).

17 “(b) TRANSFERS TO FUND.—There are hereby ap-
18 propriated to the Trust Fund the following:

19 “(1) For fiscal year 2008, \$90,000,000.

20 “(2) For fiscal year 2009, \$100,000,000.

21 “(3) For fiscal year 2010, \$110,000,000.

22 “(4) For each fiscal year beginning with fiscal
23 year 2011—

24 “(A) an amount equivalent to the net reve-
25 nues received in the Treasury from the fees im-

1 posed under subchapter B of chapter 34 (relat-
2 ing to fees on health insurance and self-insured
3 plans) for such fiscal year; and

4 “(B) subject to subsection (c)(2), amounts
5 determined by the Secretary of Health and
6 Human Services to be equivalent to the fair
7 share per capita amount computed under sub-
8 section (c)(1) for the fiscal year multiplied by
9 the average number of individuals entitled to
10 benefits under part A, or enrolled under part B,
11 of title XVIII of the Social Security Act during
12 such fiscal year.

13 The amounts appropriated under paragraphs (1), (2), (3),
14 and (4)(B) shall be transferred from the Federal Hospital
15 Insurance Trust Fund and from the Federal Supple-
16 mentary Medical Insurance Trust Fund (established
17 under section 1841 of such Act), and from the Medicare
18 Prescription Drug Account within such Trust Fund, in
19 proportion (as estimated by the Secretary) to the total ex-
20 penditures during such fiscal year that are made under
21 title XVIII of such Act from the respective trust fund or
22 account.

23 “(c) FAIR SHARE PER CAPITA AMOUNT.—

24 “(1) COMPUTATION.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the fair share per capita amount
3 under this paragraph for a fiscal year (begin-
4 ning with fiscal year 2011) is an amount com-
5 puted by the Secretary of Health and Human
6 Services for such fiscal year that, when applied
7 under this section and subchapter B of chapter
8 34 of the Internal Revenue Code of 1986, will
9 result in revenues to the CERTF of
10 \$375,000,000 for the fiscal year.

11 “(B) ALTERNATIVE COMPUTATION.—
12 “(i) IN GENERAL.—If the Secretary is
13 unable to compute the fair share per capita
14 amount under subparagraph (A) for a fis-
15 cal year, the fair share per capita amount
16 under this paragraph for the fiscal year
17 shall be the default amount determined
18 under clause (ii) for the fiscal year.

19 “(ii) DEFAULT AMOUNT.—The default
20 amount under this clause for—

21 “(I) fiscal year 2011 is equal to
22 \$2; or

23 “(II) a subsequent year is equal
24 to the default amount under this
25 clause for the preceeding fiscal year

1 increased by the annual percentage in-
2 crease in the medical care component
3 of the consumer price index (United
4 States city average) for the 12-month
5 period ending with April of the pre-
6 ceding fiscal year.

7 Any amount determined under subclause
8 (II) shall be rounded to the nearest penny.

9 “(2) LIMITATION ON MEDICARE FUNDING.—In
10 no case shall the amount transferred under sub-
11 section (b)(4)(B) for any fiscal year exceed
12 \$90,000,000.

13 “(d) EXPENDITURES FROM FUND.—

14 “(1) IN GENERAL.—Subject to paragraph (2),
15 amounts in the CERTF are available to the Sec-
16 retary of Health and Human Services for carrying
17 out section 1822 of the Social Security Act.

18 “(2) ALLOCATION FOR COMMISSION.—The fol-
19 lowing amounts in the CERTF for a fiscal year shall
20 be available to carry out the activities of the Com-
21 parative Effectiveness Research Commission estab-
22 lished under section 1822(b) of the Social Security
23 Act for such fiscal year:

24 “(A) For fiscal year 2008, \$7,000,000.

25 “(B) For fiscal year 2009, \$9,000,000.

1 “(C) For each fiscal year beginning with
2 2010, \$10,000,000.

3 Nothing in this paragraph shall be construed as pre-
4 venting additional amounts in the CERTF from
5 being made available to the Comparative Effective-
6 ness Research Commission for such activities.

7 “(e) NET REVENUES.—For purposes of this section,
8 the term ‘net revenues’ means the amount estimated by
9 the Secretary based on the excess of—

10 “(1) the fees received in the Treasury under
11 subchapter B of chapter 34, over

12 “(2) the decrease in the tax imposed by chapter
13 1 resulting from the fees imposed by such sub-
14 chapter.”.

15 (B) CLERICAL AMENDMENT.—The table of
16 sections for such subchapter A is amended by
17 adding at the end thereof the following new
18 item:

 “Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund”.

19 (2) FINANCING FOR FUND FROM FEES ON IN-
20 SURED AND SELF-INSURED HEALTH PLANS.—

21 (A) GENERAL RULE.—Chapter 34 of the
22 Internal Revenue Code of 1986 is amended by
23 adding at the end the following new subchapter:

1 **“Subchapter B—Insured and Self-Insured**
2 **Health Plans**

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans

“Sec. 4377. Definitions and special rules

3 **“SEC. 4375. HEALTH INSURANCE.**

4 “(a) IMPOSITION OF FEE.—There is hereby imposed
5 on each specified health insurance policy for each policy
6 year a fee equal to the fair share per capita amount deter-
7 mined under section 9511(c)(1) multiplied by the average
8 number of lives covered under the policy.

9 “(b) LIABILITY FOR FEE.—The fee imposed by sub-
10 section (a) shall be paid by the issuer of the policy.

11 “(c) SPECIFIED HEALTH INSURANCE POLICY.—For
12 purposes of this section—

13 “(1) IN GENERAL.—Except as otherwise pro-
14 vided in this section, the term ‘specified health in-
15 surance policy’ means any accident or health insur-
16 ance policy issued with respect to individuals resid-
17 ing in the United States.

18 “(2) EXEMPTION OF CERTAIN POLICIES.—The
19 term ‘specified health insurance policy’ does not in-
20 clude any insurance policy if substantially all of the
21 coverage provided under such policy relates to—

22 “(A) liabilities incurred under workers’
23 compensation laws,

24 “(B) tort liabilities,

1 “(C) liabilities relating to ownership or use
2 of property,

3 “(D) credit insurance,

4 “(E) medicare supplemental coverage, or

5 “(F) such other similar liabilities as the
6 Secretary may specify by regulations.

7 “(3) TREATMENT OF PREPAID HEALTH COV-
8 ERAGE ARRANGEMENTS.—

9 “(A) IN GENERAL.—In the case of any ar-
10 rangement described in subparagraph (B)—

11 “(i) such arrangement shall be treated
12 as a specified health insurance policy, and

13 “(ii) the person referred to in such
14 subparagraph shall be treated as the
15 issuer.

16 “(B) DESCRIPTION OF ARRANGEMENTS.—

17 An arrangement is described in this subpara-
18 graph if under such arrangement fixed pay-
19 ments or premiums are received as consider-
20 ation for any person’s agreement to provide or
21 arrange for the provision of accident or health
22 coverage to residents of the United States, re-
23 gardless of how such coverage is provided or ar-
24 ranged to be provided.

1 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

2 “(a) IMPOSITION OF FEE.—In the case of any appli-
3 cable self-insured health plan for each plan year, there is
4 hereby imposed a fee equal to the fair share per capita
5 amount determined under section 9511(c)(1) multiplied by
6 the average number of lives covered under the plan.

7 “(b) LIABILITY FOR FEE.—

8 “(1) IN GENERAL.—The fee imposed by sub-
9 section (a) shall be paid by the plan sponsor.

10 “(2) PLAN SPONSOR.—For purposes of para-
11 graph (1) the term ‘plan sponsor’ means—

12 “(A) the employer in the case of a plan es-
13 tablished or maintained by a single employer,

14 “(B) the employee organization in the case
15 of a plan established or maintained by an em-
16 ployee organization,

17 “(C) in the case of—

18 “(i) a plan established or maintained
19 by 2 or more employers or jointly by 1 or
20 more employers and 1 or more employee
21 organizations,

22 “(ii) a multiple employer welfare ar-
23 rangement, or

24 “(iii) a voluntary employees’ bene-
25 ficiary association described in section
26 501(c)(9),

1 the association, committee, joint board of trust-
2 ees, or other similar group of representatives of
3 the parties who establish or maintain the plan,
4 or

5 “(D) the cooperative or association de-
6 scribed in subsection (e)(2)(F) in the case of a
7 plan established or maintained by such a coop-
8 erative or association.

9 “(e) APPLICABLE SELF-INSURED HEALTH PLAN.—
10 For purposes of this section, the term ‘applicable self-in-
11 sured health plan’ means any plan for providing accident
12 or health coverage if—

13 “(1) any portion of such coverage is provided
14 other than through an insurance policy, and

15 “(2) such plan is established or maintained—

16 “(A) by one or more employers for the
17 benefit of their employees or former employees,

18 “(B) by one or more employee organiza-
19 tions for the benefit of their members or former
20 members,

21 “(C) jointly by 1 or more employers and 1
22 or more employee organizations for the benefit
23 of employees or former employees,

24 “(D) by a voluntary employees’ beneficiary
25 association described in section 501(c)(9),

1 “(E) by any organization described in sec-
2 tion 501(c)(6), or

3 “(F) in the case of a plan not described in
4 the preceding subparagraphs, by a multiple em-
5 ployer welfare arrangement (as defined in sec-
6 tion 3(40) of Employee Retirement Income Se-
7 curity Act of 1974), a rural electric cooperative
8 (as defined in section 3(40)(B)(iv) of such Act),
9 or a rural telephone cooperative association (as
10 defined in section 3(40)(B)(v) of such Act).

11 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

12 “(a) DEFINITIONS.—For purposes of this sub-
13 chapter—

14 “(1) ACCIDENT AND HEALTH COVERAGE.—The
15 term ‘accident and health coverage’ means any cov-
16 erage which, if provided by an insurance policy,
17 would cause such policy to be a specified health in-
18 surance policy (as defined in section 4375(c)).

19 “(2) INSURANCE POLICY.—The term ‘insurance
20 policy’ means any policy or other instrument where-
21 by a contract of insurance is issued, renewed, or ex-
22 tended.

23 “(3) UNITED STATES.—The term ‘United
24 States’ includes any possession of the United States.

25 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

1 “(1) IN GENERAL.—For purposes of this sub-
2 chapter—

3 “(A) the term ‘person’ includes any gov-
4 ernmental entity, and

5 “(B) notwithstanding any other law or rule
6 of law, governmental entities shall not be ex-
7 empt from the fees imposed by this subchapter
8 except as provided in paragraph (2).

9 “(2) TREATMENT OF EXEMPT GOVERNMENTAL
10 PROGRAMS.—In the case of an exempt governmental
11 program, no fee shall be imposed under section 4375
12 or section 4376 on any covered life under such pro-
13 gram.

14 “(3) EXEMPT GOVERNMENTAL PROGRAM DE-
15 FINED.—For purposes of this subchapter, the term
16 ‘exempt governmental program’ means—

17 “(A) any insurance program established
18 under title XVIII of the Social Security Act,

19 “(B) the medical assistance program es-
20 tablished by title XIX or XXI of the Social Se-
21 curity Act,

22 “(C) any program established by Federal
23 law for providing medical care (other than
24 through insurance policies) to individuals (or

1 the spouses and dependents thereof) by reason
2 of such individuals being—

3 “(i) members of the Armed Forces of
4 the United States, or

5 “(ii) veterans, and

6 “(D) any program established by Federal
7 law for providing medical care (other than
8 through insurance policies) to members of In-
9 dian tribes (as defined in section 4(d) of the In-
10 dian Health Care Improvement Act).

11 “(c) TREATMENT AS TAX.—For purposes of subtitle
12 F, the fees imposed by this subchapter shall be treated
13 as if they were taxes.

14 “(d) NO COVER OVER TO POSSESSIONS.—Notwith-
15 standing any other provision of law, no amount collected
16 under this subchapter shall be covered over to any posses-
17 sion of the United States.”

18 (B) CLERICAL AMENDMENT.—Chapter 34
19 of such Code is amended by striking the chap-
20 ter heading and inserting the following:

21 **“CHAPTER 34—TAXES ON CERTAIN**
22 **INSURANCE POLICIES**

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

1 **“Subchapter A—Policies Issued By Foreign**
2 **Insurers”.**

3 (C) EFFECTIVE DATE.—The amendments
4 made by this subsection shall apply with respect
5 to policies and plans for portions of policy or
6 plan years beginning on or after October 1,
7 2010.

8 **SEC. 905. IMPLEMENTATION OF HEALTH INFORMATION**
9 **TECHNOLOGY (IT) UNDER MEDICARE.**

10 (a) IN GENERAL.—Not later than January 1, 2010,
11 the Secretary of Health and Human Services shall submit
12 to Congress a report that includes—

13 (1) a plan to develop and implement a health
14 information technology (health IT) system for all
15 health care providers under the Medicare program
16 that meets the specifications described in subsection
17 (b); and

18 (2) an analysis of the impact, feasibility, and
19 costs associated with the use of health information
20 technology in medically underserved communities.

21 (b) PLAN SPECIFICATION.—The specifications de-
22 scribed in this subsection, with respect to a health infor-
23 mation technology system described in subsection (a), are
24 the following:

1 (1) The system protects the privacy and secu-
2 rity of individually identifiable health information.

3 (2) The system maintains and provides per-
4 mitted access to health information in an electronic
5 format (such as through computerized patient
6 records or a clinical data repository).

7 (3) The system utilizes interface software that
8 allows for interoperability.

9 (4) The system includes clinical decision sup-
10 port.

11 (5) The system incorporates e-prescribing and
12 computerized physician order entry.

13 (6) The system incorporates patient tracking
14 and reminders.

15 (7) The system utilizes technology that is open
16 source (if available) or technology that has been de-
17 veloped by the government.

18 The report shall include an analysis of the financial and
19 administrative resources necessary to develop such system
20 and recommendations regarding the level of subsidies
21 needed for all such health care providers to adopt the sys-
22 tem.

1 **SEC. 906. DEVELOPMENT, REPORTING, AND USE OF**
2 **HEALTH CARE MEASURES.**

3 (a) IN GENERAL.—Part E of title XVIII of the Social
4 Security Act (42 U.S.C. 1395x et seq.) is amended by in-
5 serting after section 1889 the following:

6 “DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE
7 MEASURES

8 “SEC. 1890. (a) FOSTERING DEVELOPMENT OF
9 HEALTH CARE MEASURES.—The Secretary shall des-
10 ignate, and have in effect an arrangement with, a single
11 organization (such as the National Quality Forum) that
12 meets the requirements described in subsection (c), under
13 which such organization provides the Secretary with ad-
14 vice on, and recommendations with respect to, the key ele-
15 ments and priorities of a national system for establishing
16 health care measures. The arrangement shall be effective
17 beginning no sooner than January 1, 2008, and no later
18 than September 30, 2008.

19 “(b) DUTIES.—The duties of the organization des-
20 ignated under subsection (a) (in this title referred to as
21 the ‘designated organization’) shall, in accordance with
22 subsection (d), include—

23 “(1) establishing and managing an integrated
24 national strategy and process for setting priorities
25 and goals in establishing health care measures;

1 “(2) coordinating the development and speci-
2 fications of such measures;

3 “(3) establishing standards for the development
4 and testing of such measures;

5 “(4) endorsing national consensus health care
6 measures; and

7 “(5) advancing the use of electronic health
8 records for automating the collection, aggregation,
9 and transmission of measurement information.

10 “(c) REQUIREMENTS DESCRIBED.—For purposes of
11 subsection (a), the requirements described in this sub-
12 section, with respect to an organization, are the following:

13 “(1) PRIVATE NONPROFIT.—The organization
14 is a private nonprofit entity governed by a board and
15 an individual designated as president and chief exec-
16 utive officer.

17 “(2) BOARD MEMBERSHIP.—The members of
18 the board of the organization include representatives
19 of—

20 “(A) health care providers or groups rep-
21 resenting such providers;

22 “(B) health plans or groups representing
23 health plans;

24 “(C) groups representing health care con-
25 sumers;

1 “(D) health care purchasers and employers
2 or groups representing such purchasers or em-
3 ployers; and

4 “(E) health care practitioners or groups
5 representing practitioners.

6 “(3) OTHER MEMBERSHIP REQUIREMENTS.—
7 The membership of the organization is representa-
8 tive of individuals with experience with—

9 “(A) urban health care issues;

10 “(B) safety net health care issues;

11 “(C) rural and frontier health care issues;
12 and

13 “(D) health care quality and safety issues.

14 “(4) OPEN AND TRANSPARENT.—With respect
15 to matters related to the arrangement described in
16 subsection (a), the organization conducts its busi-
17 ness in an open and transparent manner and pro-
18 vides the opportunity for public comment.

19 “(5) VOLUNTARY CONSENSUS STANDARDS SET-
20 TING ORGANIZATION.—The organization operates as
21 a voluntary consensus standards setting organization
22 as defined for purposes of section 12(d) of the Na-
23 tional Technology Transfer and Advancement Act of
24 1995 (Public Law 104–113) and Office of Manage-

1 ment and Budget Revised Circular A-119 (published
2 in the Federal Register on February 10, 1998).

3 “(6) EXPERIENCE.—The organization has at
4 least 7 years experience in establishing national con-
5 sensus standards.

6 “(d) REQUIREMENTS FOR EFFECTIVENESS MEAS-
7 URES.—In carrying out its duties under subsection (b),
8 the designated organization shall ensure the following:

9 “(1) MEASURES.—The designated organization
10 shall ensure that the measures established or en-
11 dorsed under subsection (b) are evidence-based, reli-
12 able, and valid; and include—

13 “(A) measures of clinical processes and
14 outcomes, patient experience, efficiency, and eq-
15 uity;

16 “(B) measures to assess effectiveness,
17 timeliness, patient self-management, patient
18 centeredness, and safety; and

19 “(C) measures of under use and over use.

20 “(2) PRIORITIES.—

21 “(A) IN GENERAL.—The designated orga-
22 nization shall ensure that priority is given to es-
23 tablishing and endorsing—

1 “(i) measures with the greatest poten-
2 tial impact for improving the effectiveness
3 and efficiency of health care;

4 “(ii) measures that may be rapidly
5 implemented by group health plans, health
6 insurance issuers, physicians, hospitals,
7 nursing homes, long-term care providers,
8 and other providers;

9 “(iii) measures which may inform
10 health care decisions made by consumers
11 and patients; and

12 “(iv) measures that apply to multiple
13 services furnished by different providers
14 during an episode of care.

15 “(B) ANNUAL REPORT ON PRIORITIES;
16 SECRETARIAL PUBLICATION AND COMMENT.—

17 “(i) ANNUAL REPORT.—The des-
18 ignated organization shall issue and submit
19 to the Secretary a report by March 31 of
20 each year (beginning with 2009) on the or-
21 ganization’s recommendations for priorities
22 and goals in establishing and endorsing
23 health care measures under this section
24 over the next five years.

1 “(ii) SECRETARIAL REVIEW AND COM-
2 MENT.—After receipt of the report under
3 clause (i) for a year, the Secretary shall
4 publish the report in the Federal Register,
5 including any comments of the Secretary
6 on the priorities and goals set forth in the
7 report.

8 “(3) RISK ADJUSTMENT.—The designated orga-
9 nization, in consultation with health care measure
10 developers and other stakeholders, shall establish
11 procedures to assure that health care measures es-
12 tablished and endorsed under this section account
13 for differences in patient health status, patient char-
14 acteristics, and geographic location, as appropriate.

15 “(4) MAINTENANCE.—The designated organiza-
16 tion, in consultation with owners and developers of
17 health care measures, shall require the owners or de-
18 velopers of such measures to update and enhance
19 such measures, including the development of more
20 accurate and precise specifications, and retire exist-
21 ing outdated measures. Such updating shall occur
22 not more often than once during each 12-month pe-
23 riod, except in the case of emergent circumstances
24 requiring a more immediate update to a measure.

1 “(e) USE OF HEALTH CARE MEASURES; REPORT-
2 ING.—

3 “(1) USE OF MEASURES.—For purposes of ac-
4 tivities authorized or required under this title, the
5 Secretary shall select from health care measures—

6 “(A) recommended by multi-stakeholder
7 groups; and

8 “(B) endorsed by the designated organiza-
9 tion under subsection (b)(4).

10 “(2) REPORTING.—The Secretary shall imple-
11 ment procedures, consistent with generally accepted
12 standards, to enable the Department of Health and
13 Human Services to accept the electronic submission
14 of data for purposes of—

15 “(A) effectiveness measurement using the
16 health care measures developed pursuant to this
17 section; and

18 “(B) reporting to the Secretary measures
19 used to make value-based payments under this
20 title.

21 “(f) CONTRACTS.—The Secretary, acting through the
22 Agency for Healthcare Research and Quality, may con-
23 tract with organizations to support the development and
24 testing of health care measures meeting the standards es-
25 tablished by the designated organization.

1 “(g) DISSEMINATION OF INFORMATION.—In order to
2 make comparative effectiveness information available to
3 health care consumers, health professionals, public health
4 officials, oversight organizations, researchers, and other
5 appropriate individuals and entities, the Secretary shall
6 work with multi-stakeholder groups to provide for the dis-
7 semination of effectiveness information developed pursu-
8 ant to this title.

9 “(h) FUNDING.—For purposes of carrying out sub-
10 sections (a), (b), (c), and (d), including for expenses in-
11 curred for the arrangement under subsection (a) with the
12 designated organization, there is payable from the Federal
13 Hospital Insurance Trust Fund (established under section
14 1817) and the Federal Supplementary Medical Insurance
15 Trust Fund (established under section 1841)—

16 “(1) for fiscal year 2008, \$15,000,000, multi-
17 plied by the ratio of the total number of months in
18 the year to the number of months (and portions of
19 months) of such year during which the arrangement
20 under subsection (a) is effective; and

21 “(2) for each of the fiscal years, 2009 through
22 2012, \$15,000,000.”.

23 **SEC. 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM.**

24 “(a) IMPLEMENTATION OF NAIC RECOMMENDA-
25 TIONS.—The Secretary of Health and Human Services

1 shall provide, under subsections (p)(1)(E) of section 1882
2 of the Social Security Act (42 U.S.C. 1395s), for imple-
3 mentation of the changes in the NAIC model law and reg-
4 ulations recommended by the National Association of In-
5 surance Commissioners in its Model #651 (“Model Regu-
6 lation to Implement the NAIC Medicare Supplement In-
7 surance Minimum Standards Model Act”) on March 11,
8 2007, as modified to reflect the changes made under this
9 Act. In carrying out the previous sentence, the benefit
10 packages classified as “K” and “L” shall be eliminated
11 and such NAIC recommendations shall be treated as hav-
12 ing been adopted by such Association as of January 1,
13 2008.

14 (b) REQUIRED OFFERING OF A RANGE OF POLI-
15 CIES.—

16 (1) IN GENERAL.—Subsection (o) of such sec-
17 tion is amended by adding at the end the following
18 new paragraph:

19 “(4) In addition to the requirement of para-
20 graph (2), the issuer of the policy must make avail-
21 able to the individual at least medicare supplemental
22 policies with benefit packages classified as ‘C’ or
23 ‘F’.”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply to medicare supple-
3 mental policies issued on or after January 1, 2008.

4 (c) REMOVAL OF NEW BENEFIT PACKAGES.—Such
5 section is further amended—

6 (1) in subsection (o)(1), by striking “(p), (v),
7 and (w)” and inserting “(p) and (v)”;

8 (2) in subsection (v)(3)(A)(i), by striking “or a
9 benefit package described in subparagraph (A) or
10 (B) of subsection (w)(2)”;

11 (3) in subsection (w)—

12 (A) by striking “POLICIES” and all that
13 follows through “The Secretary” and inserting
14 “POLICIES.—The Secretary”;

15 (B) by striking the second sentence; and

16 (C) by striking paragraph (2) .

17 **TITLE X—REVENUES**

18 **SEC. 1001. INCREASE IN RATE OF EXCISE TAXES ON TO-** 19 **BACCO PRODUCTS AND CIGARETTE PAPERS** 20 **AND TUBES.**

21 (a) SMALL CIGARETTES.—Paragraph (1) of section
22 5701(b) of the Internal Revenue Code of 1986 is amended
23 by striking “\$19.50 per thousand (\$17 per thousand on
24 cigarettes removed during 2000 or 2001)” and inserting
25 “\$42 per thousand”.

1 (b) LARGE CIGARETTES.—Paragraph (2) of section
2 5701(b) of such Code is amended by striking “\$40.95 per
3 thousand (\$35.70 per thousand on cigarettes removed
4 during 2000 or 2001)” and inserting “\$88.20 per thou-
5 sand”.

6 (c) SMALL CIGARS.—Paragraph (1) of section
7 5701(a) of such Code is amended by striking “\$1.828
8 cents per thousand (\$1.594 cents per thousand on cigars
9 removed during 2000 or 2001)” and inserting “\$42 per
10 thousand”.

11 (d) LARGE CIGARS.—Paragraph (2) of section
12 5701(a) of such Code is amended—

13 (1) by striking “20.719 percent (18.063 percent
14 on cigars removed during 2000 or 2001)” and in-
15 serting “44.63 percent”, and

16 (2) by striking “\$48.75 per thousand (\$42.50
17 per thousand on cigars removed during 2000 or
18 2001)” and inserting “\$1 per cigar”.

19 (e) CIGARETTE PAPERS.—Subsection (c) of section
20 5701 of such Code is amended by striking “1.22 cents
21 (1.06 cents on cigarette papers removed during 2000 or
22 2001)” and inserting “2.63 cents”.

23 (f) CIGARETTE TUBES.—Subsection (d) of section
24 5701 of such Code is amended by striking “2.44 cents

1 (2.13 cents on cigarette tubes removed during 2000 or
2 2001)” and inserting “5.26 cents”.

3 (g) SNUFF.—Paragraph (1) of section 5701(e) of
4 such Code is amended by striking “58.5 cents (51 cents
5 on snuff removed during 2000 or 2001)” and inserting
6 “\$1.26”.

7 (h) CHEWING TOBACCO.—Paragraph (2) of section
8 5701(e) of such Code is amended by striking “19.5 cents
9 (17 cents on chewing tobacco removed during 2000 or
10 2001)” and inserting “42 cents”.

11 (i) PIPE TOBACCO.—Subsection (f) of section 5701
12 of such Code is amended by striking “\$1.0969 cents
13 (95.67 cents on pipe tobacco removed during 2000 or
14 2001)” and inserting “\$2.36”.

15 (j) ROLL-YOUR-OWN TOBACCO.—

16 (1) IN GENERAL.—Subsection (g) of section
17 5701 of such Code is amended by striking “\$1.0969
18 cents (95.67 cents on roll-your-own tobacco removed
19 during 2000 or 2001)” and inserting “\$7.4667”.

20 (2) INCLUSION OF CIGAR TOBACCO.—Sub-
21 section (o) of section 5702 of such Code is amended
22 by inserting “or cigars, or for use as wrappers for
23 making cigars” before the period at the end.

1 (k) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to articles removed after December
3 31, 2007.

4 (l) FLOOR STOCKS TAXES.—

5 (1) IMPOSITION OF TAX.—On cigarettes manu-
6 factured in or imported into the United States which
7 are removed before January 1, 2008, and held on
8 such date for sale by any person, there is hereby im-
9 posed a tax in an amount equal to the excess of—

10 (A) the tax which would be imposed under
11 section 5701 of the Internal Revenue Code of
12 1986 on the article if the article had been re-
13 moved on such date, over

14 (B) the prior tax (if any) imposed under
15 section 5701 of such Code on such article.

16 (2) AUTHORITY TO EXEMPT CIGARETTES HELD
17 IN VENDING MACHINES.—To the extent provided in
18 regulations prescribed by the Secretary, no tax shall
19 be imposed by paragraph (1) on cigarettes held for
20 retail sale on January 1, 2008, by any person in any
21 vending machine. If the Secretary provides such a
22 benefit with respect to any person, the Secretary
23 may reduce the \$500 amount in paragraph (3) with
24 respect to such person.

1 (3) CREDIT AGAINST TAX.—Each person shall
2 be allowed as a credit against the taxes imposed by
3 paragraph (1) an amount equal to \$500. Such credit
4 shall not exceed the amount of taxes imposed by
5 paragraph (1) for which such person is liable.

6 (4) LIABILITY FOR TAX AND METHOD OF PAY-
7 MENT.—

8 (A) LIABILITY FOR TAX.—A person hold-
9 ing cigarettes on January 1, 2008, to which any
10 tax imposed by paragraph (1) applies shall be
11 liable for such tax.

12 (B) METHOD OF PAYMENT.—The tax im-
13 posed by paragraph (1) shall be paid in such
14 manner as the Secretary shall prescribe by reg-
15 ulations.

16 (C) TIME FOR PAYMENT.—The tax im-
17 posed by paragraph (1) shall be paid on or be-
18 fore April 14, 2008.

19 (5) ARTICLES IN FOREIGN TRADE ZONES.—
20 Notwithstanding the Act of June 18, 1934 (48 Stat.
21 998, 19 U.S.C. 81a) and any other provision of law,
22 any article which is located in a foreign trade zone
23 on January 1, 2008, shall be subject to the tax im-
24 posed by paragraph (1) if—

1 (A) internal revenue taxes have been deter-
2 mined, or customs duties liquidated, with re-
3 spect to such article before such date pursuant
4 to a request made under the 1st proviso of sec-
5 tion 3(a) of such Act, or

6 (B) such article is held on such date under
7 the supervision of a customs officer pursuant to
8 the 2d proviso of such section 3(a).

9 (6) DEFINITIONS.—For purposes of this sub-
10 section—

11 (A) IN GENERAL.—Terms used in this sub-
12 section which are also used in section 5702 of
13 the Internal Revenue Code of 1986 shall have
14 the respective meanings such terms have in
15 such section.

16 (B) SECRETARY.—The term “Secretary”
17 means the Secretary of the Treasury or the
18 Secretary’s delegate.

19 (7) CONTROLLED GROUPS.—Rules similar to
20 the rules of section 5061(e)(3) of such Code shall
21 apply for purposes of this subsection.

22 (8) OTHER LAWS APPLICABLE.—All provisions
23 of law, including penalties, applicable with respect to
24 the taxes imposed by section 5701 of such Code
25 shall, insofar as applicable and not inconsistent with

1 the provisions of this subsection, apply to the floor
2 stocks taxes imposed by paragraph (1), to the same
3 extent as if such taxes were imposed by such section
4 5701. The Secretary may treat any person who bore
5 the ultimate burden of the tax imposed by para-
6 graph (1) as the person to whom a credit or refund
7 under such provisions may be allowed or made.

8 **SEC. 1002. EXEMPTION FOR EMERGENCY MEDICAL SERV-**
9 **ICES TRANSPORTATION.**

10 (a) IN GENERAL.—Subsection (l) of section 4041 of
11 the Internal Revenue Code of 1986 is amended to read
12 as follows:

13 “(1) EXEMPTION FOR CERTAIN USES.—

14 “(1) CERTAIN AIRCRAFT.—No tax shall be im-
15 posed under this section on any liquid sold for use
16 in, or used in, a helicopter or a fixed-wing aircraft
17 for purposes of providing transportation with respect
18 to which the requirements of subsection (f) or (g) of
19 section 4261 are met.

20 “(2) EMERGENCY MEDICAL SERVICES.—No tax
21 shall be imposed under this section on any liquid
22 sold for use in, or used in, any ambulance for pur-
23 poses of providing transportation for emergency
24 medical services. The preceding sentence shall not
25 apply to any liquid used after December 31, 2009.”.

1 (b) FUELS NOT USED FOR TAXABLE PURPOSES.—

2 Section 6427 of such Code is amended by inserting after
3 subsection (e) the following new subsection:

4 “(f) USE TO PROVIDE EMERGENCY MEDICAL SERV-
5 ICES.—Except as provided in subsection (k), if any fuel
6 on which tax was imposed by section 4081 or 4041 is used
7 in an ambulance for a purpose described in section
8 4041(l)(2), the Secretary shall pay (without interest) to
9 the ultimate purchaser of such fuel an amount equal to
10 the aggregate amount of the tax imposed on such fuel.
11 The preceding sentence shall not apply to any liquid used
12 after December 31, 2009.”.

13 (c) TIME FOR FILING CLAIMS; PERIOD COVERED.—

14 Paragraphs (1) and (2)(A) of section 6427(i) of such Code
15 are each amended by inserting “(f),” after “(d),”.

16 (d) CONFORMING AMENDMENT.—Section 6427(d) of
17 such Code is amended by striking “4041(l)” and inserting
18 “4041(l)(1)”.

19 (e) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to fuel used in transportation pro-
21 vided in quarters beginning after the date of the enact-
22 ment of this Act.



CMS LIBRARY



3 8095 00013944 0